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American Health Care: Justice, Policy, Reform

Carolyn Conti

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**AMERICAN HEALTH CARE:
JUSTICE, POLICY, REFORM**

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Carolyn Ann Conti

December 2010

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Carolyn Ann Conti

2010

**AMERICAN HEALTH CARE:
JUSTICE, POLICY, REFORM**

By

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Approved October 4, 2010

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ABSTRACT

AMERICAN HEALTH CARE: JUSTICE, POLICY, REFORM

By

Carolyn Ann Conti

December 2010

Dissertation supervised by Professor Aaron L. Mackler

The American health care system is seriously flawed and in need of reform. American health care is expensive and rationed by the ability to pay. More than forty-five million Americans lack regular access to health care because they have no health insurance and cannot afford to pay for care on their own. An even greater number of Americans have inadequate access to health care because their health insurance provides insufficient coverage. Even well-insured Americans, most of whom get their health insurance through their employers, have problems because their out-of-pocket expenses are escalating while their coverage is shrinking.

Contemporary public discourse suggests that many if not most Americans are dissatisfied with the health care system as it is currently structured and are ready for change but are uncertain about how to achieve reform. Although the American people disagree about what a reformed health care system should be they are nearly unanimous

in their dissatisfaction with both access to and cost of health care. The voice of the American people needs to be focused into a coherent, cohesive message calling for reform and the message must be honed and repeated to exert pressure on the government to act in accord with the will of the people rather than that of special interest groups.

This dissertation will address the issue of what the American people can do to effect comprehensive reform of the American health care system, focusing on how to begin the process and not on what the reformed system should be. The thesis of this dissertation is that a social reform movement is in order and might be necessary in order to accomplish comprehensive reform of American health care. The thesis will develop in three parts, examining American health care from three perspectives, justice, policy, and reform.

Part One will focus on why reform is necessary. Part Two will focus on why a social reform movement is in order. Part Three will focus on what the American people can do to accomplish the successful reform of the American health care system that has so far eluded the political and legislative processes.

DEDICATION

Dedicated to

My Beloved Holy Spirit, Who inspired me to begin this journey and guided me at every step along the way...

And

My very dear friend and mentor, Father Herbert Ryan, S.J., who believed in me more than I believed in myself...

And

My beloved family: My mother Irene who would not let me quit,
My brother Frank, who opened his home to me, and
My niece Stacy, who convinced me to get up and dance.

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Part One: Justice

Chapter One:

Justice: In Theory, A General Understanding

Chapter Two:

Justice: In Practice, Applied to Health and Health Care

Chapter One

Justice: In Theory, A General Understanding

I. Introduction

A doctoral dissertation is expected to make a new and creative contribution to the field of study by presenting an original topic or a new point of view. This dissertation will focus on reform of the American health care system, from a heretofore unexplored or underexplored perspective, specifically that of how to accomplish substantive, comprehensive reform by persuading Americans to become actively involved in the process and by developing a blueprint or framework for American activists to follow in beginning the effort to accomplish reform.¹ The dissertation offers analysis and reasons that suggest a social reform movement might strengthen the political will to act to reform the American health care system.

The primary focus of the dissertation is to persuade the reader of the thesis but a secondary focus is to inspire American activists to challenge Americans to accomplish

¹ Existing literature presents many arguments and reasons regarding why the American health care system should be reformed, calling on the many existing theories of justice and developing new ideas for applying these theories. Existing literature presents the many and varied types of health care systems implemented by every other developed nation and attempts to suggest how these ideas might be adopted and adapted by the United States. Existing literature presents the many attempts to achieve reform of the American health care system and develops a wide variety of explanations regarding why these many attempts have failed. Existing literature does not present how the United States might actually accomplish health care reform by getting the American people involved in the effort. This dissertation is an attempt to fill this void in the existing literature, moving outside academic argument and analysis to present and develop a practical approach to achieving reform. The goal is to construct a blueprint for the American people to follow in order to compel the government to listen to the will of the people rather than the special interest groups.

health care reform by beginning and sustaining a social reform movement. The general thesis of this dissertation is that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have, in general, not succeeded. While it is true that health insurance reform legislation was enacted very recently in March 2010, this does not mitigate the need for a sustained social reform movement. This legislation represents a significant first step on the way to substantive reform of the American health care system, but a first step does not necessarily mean the entire journey will be successful. Social activists will need to keep the idea of comprehensive reform at the forefront of the hearts and minds of the American people so that they are so committed to health care reform that the government must complete the work of reform in response to the will of the people. Thus, in spite of the recent success in enacting health insurance reform legislation, the need for an active social movement for health care reform is pervasive.²

The dissertation will be developed in three parts, examining the issue of health care reform from three perspectives: Part One will focus on Justice; Part Two will focus on Policy; and Part Three will focus on Reform.

A. Map of Part One

Part One does not attempt to break new ground in developing a new theory of justice, but instead draws on extensive writings by scholars in the field to argue that Americans have a moral right to health care, a right that is not being honored under the

² It should also be noted that the ideas, lessons, and suggestions presented in this dissertation can be applied to any movement aimed at accomplishing social reform, in the United States and elsewhere.

American health care system as it is currently structured. Since justice demands that a rights violation be redressed, Part One thus establishes a basis for calling for reform of the American health care system. Part One will be developed in two chapters. Chapter One will develop the thesis by drawing on various approaches to justice, examining several theories and definitions of justice, including social justice and distributive justice, and arguing that a moral right to health care can be based on the Golden Rule (Ethic of Reciprocity) or the terms of fair cooperation justifiable in a democratic society that espouses freedom and equality for all. Chapter Two will develop the thesis by moving from a theoretical understanding of justice that supports a moral right to health care to applying the theories to the practical problems of developing a just or more just health care system for Americans. Chapter Two will examine the works of several scholars in the field,³ analyze their arguments, and argue that their work supports a moral right to health care on several bases but that it takes more than a moral right to accomplish reform in the practical sense. Further, while a moral right to health care may be necessary to call for reform, it may not be sufficient to persuade Americans to take action. Therefore the works of two other scholars are examined,⁴ one of whom argues for a moral right to health care as a derivative of the obligation to aid those in need and the other of whom argues for a moral right to health care as a corollary of enlightened self-interest. Thus, a moral right to health care, necessary for calling for reform, can be supported based on the Golden Rule or Ethic of Reciprocity, the terms of fair cooperation justifiable in a

³ The scholars are: Daniel Wikler; Norman Daniels; Madison Powers and Ruth Faden; and Erich H. Loewy and Roberta Springer Loewy.

⁴ The scholars are: Charles J. Dougherty and Larry R. Churchill.

democratic society, as a derivative of the obligation to aid those in need, or as a corollary to enlightened self-interest. However, this moral right is not sufficient to accomplish reform because, in contemporary American society, a moral right must be transformed into a legal right in order to be recognized and honored and this can only be done through the political and legal processes. Thus, Part One leads to Part Two for an examination of policy.

B. Map of Part Two

Part Two of this dissertation will focus on Policy, the high-level framework or plan of action that embraces the general goals and guides the decisions and actions of an organization or institution such as the government, with particular regard to health care policy. Policy is an important step on the road to health care reform because it will ultimately provide the foundation that will transform the moral right to health care, as supported by Part One of this dissertation, into a recognized legal right. Part Two will be developed in two chapters. Chapter Three will develop the thesis by first presenting a general introduction to policy and an overview of different types or categories of health care systems as these systems have been and are continuing to be developed in other nations. Chapter Three will then examine the health care systems of four representative nations: Germany, Great Britain, Canada, and France. Chapter Three will argue that the health care systems of the paradigm nations, as has been the case in many if not all of the other nations that have developed universal access health care systems, developed on the basis of the health care system that already existed. This could be of significant relevance and also a valuable lesson for American reformers, that reform is more likely to succeed through evolutionary, not revolutionary, change. Chapter Four will develop the

thesis by examining America's social welfare policy, specifically five paradigms,⁵ both successes and failures, to determine whether and how the repeated failures of health care reform might be overcome. The focus will be pragmatic achievability, presenting practical suggestions to create a workable solution to what has heretofore been an insoluble problem. Chapter Four will argue that the American people were actively involved in the two successful attempts to enact social welfare legislation, Social Security and Medicare, but that such activism was missing in the other attempts⁶ and that therefore the active involvement of the American people may be necessary in order to accomplish reform. Thus, Part Two gives way to Part Three and an examination of how reform may be accomplished.

C. Map of Part Three

This dissertation proposes an alternative method for achieving reform through the active involvement of American citizens fomenting a social reform movement to accomplish the reform that has not been achieved through the political and legislative processes. A social reform movement would not replace political effort but would instead both complement and supplement the work of the political and legislative processes. Thus, Part Three will focus on Reform, specifically on how social reform movements accomplish reform and how a social movement for health care reform might begin and develop in contemporary American society. Part Three will develop in four chapters. Chapter Five will develop the thesis by providing necessary background

⁵ The five paradigms are: FDR and Social Security; Truman and national health insurance; LBJ and Medicare/Medicaid; Nixon and HMOs; and Clinton and the Health Security Act.

⁶The three unsuccessful attempts to achieve reform of the American health care system were: National Health Insurance under Truman; HMOs under Nixon; and the Health Security Act under Clinton.

information on social reform movements in general, what they are and how they accomplish reform. Although social reform movements usually begin when governments are unable or unwilling to take necessary action to redress injustice, the ultimate resolution of the injustice must be accomplished through government action. Chapter Five will argue that government must play a role in both accomplishing reform and the newly reformed social program. Chapter Six will develop the thesis by examining the work of the first American social reform movement, abolition, and extracting lessons that may be applied to a contemporary social movement for health care reform. Chapter Seven will develop the thesis by examining the work of the second American social reform movement, woman's rights and suffrage, and extracting lessons that may be applied to a contemporary social movement for health care reform. These two social reform movements are examined because they developed somewhat differently and thus have unique as well as common lessons for contemporary social reform activists. Chapter Eight will develop the thesis by clarifying the work to be done by American social reform activists in beginning and sustaining a health care reform movement and by addressing implications for related fields such as health care ethics. Chapter Eight will conclude with a brief summary of the major points of the dissertation and how each point helped to develop the thesis.

D. Scope of Part One

Part One will develop an understanding of justice at the theoretical level that may be acceptable to all or nearly all Americans and support a moral right to health care. This moral right to health care is not grounded in a philosophical foundation for human rights. It is beyond the scope of this dissertation to develop a philosophical foundation for a right

to health care, if in fact it would be possible to develop such a foundation.⁷ Furthermore, developing, demonstrating, or proving a proper philosophical foundation for human rights in general and a right to health and health care in particular will not help in setting the priorities and resolving the conflicts that must be set and resolved in any health care system. Rather, a moral right to health and health care is a corollary of our “social obligation to ensure fair equality of opportunity [and] promote normal functioning and is tied to the terms of fair cooperation that are justifiable within a society of free and equal individuals.”⁸ A moral right to health and health care that derives from social obligations and the terms of fair cooperation within a just society should be an adequate basis for arguing that the American health care system as it is currently structured is unjust and therefore must be reformed.

⁷ Establishing a philosophical foundation for a right to health care might answer at a most fundamental level why Americans need to reform their health care system but scholars argue that such a foundation is not necessary to understand why American health care, as currently structured, is unjust. In *Just Health*, Daniels argues that searching for a philosophical foundation for human rights in general and a right to health care in particular confuses the issue of what must be done in order to achieve a just or more just health care system. Claiming a human right to health care does not settle disagreements about the scope and limits of such rights claims or tell what entitlements flow from the rights claims. Having a philosophical foundation for a human right to health care will not resolve practical disputes about what the rights imply. Other scholars, for example Albert Jonsen, Stephen Toulmin, and Daniel Wikler, also argue that it is possible to agree on a right course of action without agreeing on why this is so and that it is possible to reach consensus on what to do without agreeing on underlying reasons. See Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York, NY: Cambridge University Press, 2008), pp. 14-16 and 314-26; Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley and Los Angeles, CA: University of California Press, 1988), pp. 16-19 and p. 14; Daniel Wikler, "Philosophical Perspectives on Access to Health Care: An Introduction," in *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services; Volume Two: Appendices, Sociocultural and Philosophical Studies*, ed. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, DC: U.S. Government Printing Office, 1983), 108-51.

⁸ Daniels, *Just Health*, pp. 316-17.

E. Scope of Chapter One

Chapter One will develop the thesis, that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have not succeeded, by examining justice in the theoretical sense, from a general philosophical concept to social justice and distributive justice⁹ to develop an understanding of justice that is both acceptable to all or nearly all Americans and also supports the argument for a moral right to health care. This chapter will work to develop an understanding of justice grounded not in the abstract conceptual sense but rather in a concrete understanding of what justice in theory demands of us as members of a society and a community. This concrete understanding of justice may be thought of as an innate understanding of the code of behavior that advises human beings how to behave toward one another, an implicit covenant that transcends the implied social contract, a covenant that informs and governs what we owe to one another as members of the universal community of mankind and the local community of all Americans.

F. Golden Rule or Ethic of Reciprocity

The implicit covenant that transcends the implied social contract and informs and governs what we owe one another follows from the precept commonly called the Golden

⁹ There are many additional types or categories of justice, for example, legal justice and retributive justice. However, social justice and distributive justice are most pertinent to the thesis of this dissertation.

Rule.¹⁰ Some form or understanding of the Golden Rule is espoused by all or nearly all world religions. In secular terms, the Golden Rule becomes the Ethic of Reciprocity.¹¹

The ethic of reciprocity is a fundamental moral value referring to the balance in an interactive system, such as a society or a community, such that each member of the society or community has both rights and duties; a subordinate norm of complementarity states that one's rights are the other's obligation. In essence it is an ethical code under which each member of a society or community has a moral right to just treatment and a corresponding duty or responsibility to ensure justice for others. This ethic or rule indicates that we must treat one another as we ourselves wish to be treated, and that we owe and must extend to each other what we expect others to extend to us. This has specific application to and implications for health care reform.

II. Justice As Theory: A Brief Overview

If a moral right to health care exists, under the terms of cooperation of the implied social contract and/or the innate understanding of just behavior toward one another of the implicit covenantal code of behavior that informs social interaction, then the current American health care system, a system that does not provide access to health care for all Americans, is unjust¹² and reform is in order. Therefore, a discussion of justice is

¹⁰ A commonly recited version of the Golden Rule is do unto others as you would have them do unto you or love your neighbor as yourself. For variations on the Golden Rule check the Religious Tolerance website at <<http://www.religioustolerance.org/reciproc.htm>>.

¹¹ John Rawls argues that the idea of reciprocity is implicit in the notion of a well-ordered society. See John Rawls, *A Theory of Justice*, 1971, revised edition (Cambridge, MA: Harvard University Press, 1999), pp. 88-90.

¹² In contemporary American idiom, the health care system would probably be described as unfair rather than unjust because most Americans tend to use the terms just and unjust in regard to the legal system.

germane to a doctoral dissertation that focuses on reform of the American health care system because it provides a supportive rationale for calling for reform.

The ultimate goal of this dissertation is twofold: to develop and present arguments that will impel the American people to begin the work that will create a groundswell of commitment to health care reform, a groundswell that will compel the American government to accomplish that reform according to the will of the people and to create a blueprint or framework to guide the work to be done to achieve reform. In order to accomplish this change, this social reform, from the bottom up, it will be necessary to hone and strengthen the political will of a majority of the American people to take the action that will inform the government that the will of the people must override and supersede the will of special interest groups. But prior to beginning the work of shaping and strengthening the political will of the American people to agitate for reform, it is important to establish the basis for the work to be done, starting with an understanding of justice.

The concept or idea of justice has been debated, defined, and discussed for all or nearly all of recorded history and most probably for millennia prior to the invention of writing. The ancient Greek philosophers contributed to the body of knowledge regarding justice and so did the Fathers of early Christianity and Jewish scholars and rabbis. The discussion of justice continued throughout the medieval period, into the age of the Enlightenment, and forward into contemporary thinking. This section of Chapter One will present a brief discussion of the somewhat abstract philosophical concept of justice in general, followed by discussion of social justice and distributive justice, and conclude with a more practical or concrete understanding of justice that can provide impetus to the

work of health care reform. Justice, a concept of moral rightness based on several factors including ethics, rationality, law, natural law, fairness, and equity, is one of the key features of society but views of what constitutes justice vary from society to society and person to person.

A. Justice As A Philosophy

What is Justice? The meaning of this abstract term has been discussed and debated for millennia from before ancient Greece to today. For Plato, justice meant a harmonious relationship within the city, a commonwealth where “each one must practice one of the functions in the city, that one for which his nature made him naturally most fit.”¹³ For Aristotle, however, in the *Nichomachean Ethics*, justice was “the virtue preeminently concerned with right relationships with others.”¹⁴ John Locke, Enlightenment philosopher and natural law theorist, linked justice to the preservation of property rights while Karl Marx defined justice as from each according to ability and to each according to need. Contemporary political philosophers Robert Nozick and John Rawls have very different ideas of what constitutes justice. Nozick ties justice to property rights starting with current property holdings. A distribution of property is just if everyone is entitled to the holdings they possess. Rawls considers fair allocation of property and other benefits and contends that justice is based on principles of equal liberty and equal opportunity to acquire the benefits of society coupled with a sub-

¹³ Plato, *The Republic of Plato*, 1968, translated by Allan Bloom, Second Edition (New York, NY: Basic Books, Inc., 1991), Book IV, n. 433a.

¹⁴ Aristotle, *Nichomachean Ethics*, translated by Martin Ostwald (New York, NY: Macmillan, 1986), Book 5; Mary J. McDonough, *Can a Health Care Market Be Moral: A Catholic Vision* (Washington, D.C.: Georgetown University Press, 2007), p. 11.

principle of distributive justice that permits inequalities so long as these inequalities redound to the advantage of all and especially to the least well off in society.

1. Augustine and Aquinas

Augustine addressed the social dimension of justice, arguing that people can only become fully human through living in society and that justice directs all citizens to the common good of society. Without justice there can be no true society.¹⁵ Thomas Aquinas, great Scholastic thinker, reinterpreted Aristotle in light of Christian revelation and grounded his theology in the Aristotelian view that people have a communitarian nature so that what is good for each person is connected to the good of the community. Social relationships in a political community are necessary for people to perfect their humanity and these relationships refine the notion of the common good. Justice, defined by Aquinas in the classic sense of paying what is due, “is essential in guiding human action toward the common good.”¹⁶

B. Common Threads Unifying Justice As A Philosophy

In analyzing the various definitions of and ideas about justice, from the ancient Greeks through contemporary times, the common threads or unifying notions are those of man as a social being¹⁷ and relationship, individual to individual, individual to community or society, and community or society to individual. The concept of justice

¹⁵ For additional information on Augustine’s teachings, see McDonough, *Health Care Market*, pp. 11-13.

¹⁶ McDonough, *Health Care Market*, p. 13.

¹⁷ Aristotle and Thomas Aquinas both emphasized the social nature of man. This understanding of man as a social being is essential to the idea of the common good, an idea that is basic to health care reform. See Daniel Callahan, "America's Blind Spot: Health Care & the Common Good," *Commonweal* CXXXVI, no. 17 (9 Oct 2009).

would be meaningless in a vacuum. If an individual were living in total isolation, apart from family, community, or society, assuming it were even possible for that individual to develop fully as human, s/he would have no concept of justice and no reason to consider justice. This dovetails with the Golden Rule or Ethic of Reciprocity. Justice informs and governs how we relate to one another and how we relate to community and society.

Justice informs and governs what we owe to one another and what we owe to community and society. Justice informs and governs what others, individuals, community, and society, owe to us. Thus, despite different terminology and emphases in defining justice, the unifying notion of relationship argues that justice for anyone is meaningless without justice for all. However, in spite of a unifying notion of fairness in relationships and social interactions, ideas of justice still differ significantly and because of this, the question of agreement on ideas of justice must be asked.

C. Shared or Minimalist Concept of Justice

1. Thin Concept of Justice or Morality

In today's world of complex societies with culturally and historically conditioned values and morality, it is still possible to relate to issues of Justice outside our own sphere of experience. There exists a minimal or thin concept of justice that allows us to transcend the fullness or totality of our own thick, maximal, culturally integrated morality and relate to the core morality of others, a core that exists in all. Although "we have different histories, we have common experiences and out of these we fashion the moral minimum."¹⁸ This thin or minimalist concept of justice¹⁹ is not foundational. Rather, it

¹⁸ Michael Walzer, *Thick and Thin: Moral Argument at Home and Abroad* (Notre Dame, IN: University of Notre Dame Press, 1994), pp. 17-18.

is embedded in the thick, maximal, specific morality associated with a cultural, historical, political, religious orientation.

Crisis, such as the current global economic crisis or the ongoing crisis of the American health care system, frees the minimal concept of justice from its maximal foundation. When this occurs, a shared concept of justice becomes universally accessible²⁰ because we have a common understanding of injustice. Although we may not agree specifically on what constitutes justice in practice, we can and do recognize the idea of justice espoused by others as an antidote to injustice. Thus, “minimalism makes for a certain limited, though important and heartening, solidarity.”²¹ Minimalism is mutual recognition that historically and culturally conditioned ideas about morality and justice are similar even though they are expressed in different idioms. This commonality depends on the fact that “we have moral expectations about the behavior not only of our fellows but of strangers too.”²²

2. Locus of Certitude

Since maximal or thick ideas of justice and all moral values are developed in and conditioned by history, culture, and political or religious orientation, how is it possible for individuals of varying backgrounds and interests to reach consensus on ethical issues or questions of justice? This agreement or consensus is possible because individuals

¹⁹ The idea applies to any moral value, but the connection with justice is most pertinent to the topic at hand.

²⁰ Perhaps crisis allows us to look past the walls and barriers of our own thick morality to reach some essential understanding of justice accessible by all.

²¹ Walzer, *Thick and Thin*, p. 11.

²² Walzer, *Thick and Thin*, p. 17.

have a capacity for phronesis,²³ an ability to recognize significant particulars and to use informed prudence or practical wisdom in reaching ethical decisions and addressing questions of justice. Thus, although individuals may disagree on why a specific course of action is necessary, they can agree on what course of action is necessary.

This locus of certitude²⁴ lies not in a shared set of intrinsically convincing general rules or principles but in a shared perception of what specifically is at stake in a particular situation. Thus, in a practical sense, we can reach agreement on what is right and just, even if our underlying individual reasons differ.

A minimalist understanding of justice and the locus of certitude permit individuals of vastly different backgrounds and ideologies to agree on specific courses of action to resolve complex ethical issues and redress injustice. Understanding that it is possible for individuals of differing viewpoints and ideologies to agree on doing what is right and just, even if their reasons for agreeing to a course of action are different, is important in developing an understanding of justice that all or nearly all will accept.

²³ Phronesis is an Aristotelian term that refers to an aspect of our calculative reasoning that helps us to find the virtuous mean between extremes. Phronesis or practical wisdom has two components. First, it involves an intuitive knowledge of our ultimate purpose in life, that is, to be community-oriented, rational creatures. Each properly formed virtue contributes to fulfilling this ultimate purpose. Second, Phronesis involves deliberating about and planning the best way of attaining this ultimate purpose. In facing and deciding each ethical dilemma, phronesis helps us to determine the appropriate course of action. See James Fieser, *Moral Philosophy Through the Ages* (Mountain View, CA: Mayfield Publishing Company, 2001), pp. 38-39.

²⁴ Albert Jonsen and Stephen Toulmin introduced this concept of locus of certitude to explain how the eleven members of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, who had varied backgrounds and interests, were able to reach agreement about specific practical recommendations regarding complex ethical issues. See Jonsen and Stephen Toulmin, *Abuse of Casuistry*, pp. 16-19 and p. 14.

D. Recap

Thus, justice concerns the proper ordering of things and persons within a society.²⁵ According to most theories of justice, it is overwhelmingly important, the first virtue of social institutions, and is distinct from and more fundamental than other virtues such as benevolence, charity, mercy, generosity, or compassion.

Since an understanding of justice is of overwhelming importance to society, it is appropriate to consider social justice, the “relationship between the [individual] person and society.”²⁶

III. Social Justice

Social justice refers to a concept of a society in which justice is achieved in every aspect and not just in the administration of law. The socially just society affords individuals and groups fair treatment and an equitable sharing of the burdens and the benefits of society.²⁷ Social justice is both a philosophical concept and an important issue in politics, religion, and civil society. It has a central place in Judaism and is fundamental to Catholic social teaching.

²⁵ The question of what constitutes society has been much debated. For the purposes of this dissertation, society refers to, in general, the universal community of all mankind, and in particular, the local community of all American citizens/residents.

²⁶ McDonough, *Health Care Market*, p. 17.

²⁷ Different proponents of social justice have different interpretations of what constitutes ‘fair treatment’ and ‘impartial share.’

A. Social Justice and Religious Traditions

1. Judaism and Social Justice

Social justice relates to two key emphases in the Jewish tradition, a primary focus on community and an equally important focus on obligation. To be Jewish is to be a member of the community, with obligations imposed by God's commandments, and further conditioned by history, from the strong community orientation of the tribal culture of the Ancient Near East, through centuries of exile and dispersion, when Jews were forced to exist outside the construct of the larger society, without the rights or protection of citizenship. Thus the burden of obligation to care for one another fell on the community itself. Although in more recent history Jews have become citizens of the larger nation-states, neither the community orientation nor the sense of duty or obligation has in any way diminished. Throughout history, "Judaism has striven to understand the demands of justice, and to develop institutions in society that can achieve them."²⁸ Justice is more than compassion and generosity: justice is foundational.

Judaism embodies an ethics of responsibility, distinctive and challenging beliefs conceptualized by abstract ideas such as *tzedakah* that are actualized in the community. *Tzedakah*, literally justice, is support for the poor and involves enforceable (under Jewish law) obligations for the community and the members of the community. "The basic understanding and practice of *tzedakah* is shared among all normative Jewish sources, from the Mishnah and Talmud of almost two thousand years ago through contemporary

²⁸ Aaron L. Mackler, "Judaism, Justice, and Access to Health Care," *Kennedy Institute of Ethics Journal* 1, no. 2 (June 1991): p. 143.

legal responsa.”²⁹ Justice demands that no individual should be exploited and that each individual should have at least a basic level of material security. *Tzedakah* provides the means for ensuring that each has this basic level.

Each member of the community is obligated to give *tzedakah* and this obligation is analogous to the payment of income tax in the United States.³⁰ From this general fund, resources are redistributed according to the needs of the poor. Need is a somewhat elastic term, but the tradition interprets it to mean basic support but not enrichment. Basic needs are implicit, including food, clothing, shelter, and the opportunity for family life.

Thus the community is obligated to provide for all of its members, including or even especially for those who cannot provide for themselves. The Jewish tradition specifies the minimum level of support required, from the perspective of both the giver and the receiver. The giver is generally required to pay one-tenth of all income including acquired capital. “Giving one-fifth represents ‘choice’ fulfillment of the obligation, and one should give ‘according to the needs of the poor,’ even above one-fifth of one’s income, if one can afford to do so.”³¹ The minimum level of required support, from the perspective of the receiver, is based on need or lack. The community is obligated to supply that which is missing.

²⁹ Mackler, "Judaism, Justice, and Access," p. 144.

³⁰ The obligation is on all so that even the poor must pay from their limited resources into the communal fund. This truly emphasizes justice over charity; it is not that the rich give to the poor, but rather that all contribute something in order to provide for those in need or in greater need. If all contribute, then no one is getting something for nothing. Rather, all assume the obligation of providing for all who need help.

³¹ Elliot N. Dorff and Aaron L. Mackler, "Responsibilities for the Provision of Health Care," in *Life and Death Responsibilities in Jewish Biomedical Ethics*, ed. Aaron L. Mackler (New York, NY: The Jewish Theological Seminary of America, 2000), p. 484.

2. Justice and Catholic Social Teaching

The Catholic Church has a rich justice tradition, a tradition rooted in its social teachings that has evolved over centuries from Augustine and Thomas Aquinas, who provide an essential foundation for Catholic justice theory, to more recent papal encyclicals. Catholic social justice theory has been and is being continually reinterpreted and applied to contemporary situations. A distinctive feature of Catholic social teaching is the special concern for the poorest members of society. Two key areas³² of Catholic social teaching are pertinent to social justice:³³ the life and dignity of the human person and the preferential option for the poor and vulnerable.

Modern Catholic teaching about social justice and human rights began with the encyclical *Rerum Novarum* (On the Condition of the Working Classes)³⁴ issued by Pope Leo XIII in 1891. Leo XIII expressly rejected socialism but defended labor unions and the right to private property as the right of families to self-preservation. A key element of *Rerum Novarum*, a thread that will tie together all the teachings and documents of the next hundred years, is the emphasis on the inherent dignity of the human person, the measure by which all political, legal, and social institutions are to be judged. Respecting human dignity requires that government help the people and act in accordance with the common good. Justice requires positive acts that actively promote the common good.

³² , United States Conference of Catholic Bishops (USCCB), 19 June 2009
<<http://www.nccbuscc.org/sdwp/projects/socialteaching/excerpt.htm>>.

³³ Jesuit Luigi Taparelli coined the term “social justice,” based on the teachings of Thomas Aquinas, in the mid-nineteenth century. Taparelli wrote extensively, engaging both capitalist and socialist theories from a natural law viewpoint. His basic premise was that the rival economic theories undermined the unity of society present in Thomistic metaphysics since neither the liberal capitalists nor the communists concerned themselves with public moral philosophy.

³⁴ See McDonough, *Health Care Market*, pp. 14-16.

In *Quadragesimo Anno*,³⁵ a 1931 encyclical On the Reconstruction of the Social Order, Pope Pius XI emphasized the relationship between the person and society, the individual and the common good. This relationship, known as social justice, requires that governments guarantee and protect the rights of their citizens. Pius XI also introduced the principle of subsidiarity, limiting the government's power to intervene to only whatever is necessary to provide distributive and social justice. Justice requires a system of social organizations that allow the person to develop fully. The individual has the right to a government system that protects human rights and the role of government is to promote the common good.

In *Mater et Magister* (Christianity and Social Progress),³⁶ Pope John XXIII emphasized that, despite increased involvement by public authorities in the lives of individuals in areas such as health care, education, career choice, and assistance for the disabled, the individual was necessarily the foundation, cause, and end of all social institutions. The person was and is the purpose of economic and social life.

In *Pacem in Terris* (Peace on Earth), John XXIII enumerated a list of human rights, including a right to medical care,³⁷ which is considered to be the “most complete and systematic list of these human rights in the modern Catholic tradition.”³⁸ These rights derive from the dignity of the human person and come with corresponding duties.

³⁵ See McDonough, *Health Care Market*, pp. 16-20.

³⁶ See McDonough, *Health Care Market*, pp. 20-22.

³⁷ See the encyclical *Pacem in Terris*, par. 11, found in "Catholic Social Thought: The Documentary Heritage," in *Catholic Social Thought: The Documentary Heritage*, ed. David J. O'Brien and Thomas A. Shannon (Maryknoll, NY: Orbis Books, 1992), pp. 131-62.

³⁸ David Hollenbach, *Claims in Conflict: Retrieving and Renewing the Catholic Human Rights Tradition* (New York, NY: Paulist Press, 1979), p. 66.

The protection of human rights calls for organized action within society and government action, although not the sole guarantee of human rights, is indispensable for the protection of all rights. Social rights specify positive obligations of society toward all its members.

In *Octogesima Adveniens*,³⁹ Paul VI's claim that human dignity requires equality and a right to participate in social, economic, and political decisions marked a major progression in Catholic social thought. In the same Apostolic Letter, Paul VI also emphasized the preferential option for the poor, arguing that the "more fortunate are required to help the less fortunate."⁴⁰

Catholic social teaching on justice has evolved substantially since the writings of Augustine and Thomas Aquinas and as Catholic social teaching has developed, central themes⁴¹ characterizing Catholic social justice tradition have emerged.

Human dignity, the first principle of Catholic social justice teaching, requires that all people be viewed and treated as fundamentally equal and that they be able to develop a full range of capacities, including, but not limited to, rights to food, clothing, shelter, medical care, education, religious expression, and others. In order to achieve these rights, people must be able to participate in the economic, political, and social processes that affect their lives.

Social interdependence, the second principle of Catholic social teaching, means that justice cannot be understood apart from the reality of a labyrinth of social

³⁹ See McDonough, *Health Care Market*, pp. 25-28.

⁴⁰ McDonough, *Health Care Market*, p. 27.

⁴¹ See McDonough, *Health Care Market*, pp. 32-34.

relationships. Human dignity is totally interrelated with political, social, and economic structures and therefore “not only is the distribution of public goods within society important, but so is the relationship between the person and society.”⁴² Thus distributive justice, overseeing the allotment of societal goods, commutative justice, regulating the dealings between individuals, and social justice, governing the relationship between the individual and society, all come into play.

The third principle of Catholic social teaching, the common good, is the notion that the good of the community is more important than the good of the individual. In conjunction with the principle of social interdependence, this requires positive acts by various sectors of society that actively promote the common good. The common good consists of human rights and duties that promote and protect dignity.

The fourth principle of Catholic social teaching, the special obligation to the poor and vulnerable, requires that special attention be given to their needs. Because of difficult economic conditions, discriminatory practices, and other factors that marginalize them, the poor and vulnerable are often unable to develop their full human potential as required by the principle of promoting human dignity. “Not only are they often excluded from participating in the political, economic, and social processes that affect their lives, but their basic material needs, such as sustaining levels of food and adequate shelter, are often not met.”⁴³ Justice thus requires that the Church, individuals, and society as a whole make special efforts to ensure that the poor and vulnerable are able to attain their full human dignity.

⁴² McDonough, *Health Care Market*, p. 33.

⁴³ McDonough, *Health Care Market*, p. 33.

3. Social Justice and Other Religious Traditions

Other religious traditions embody an understanding of social justice or social ethics. The Lutheran tradition, for example, in their diaconal movement, clearly saw that “sickness and health were related to economic and social conditions, including work environments, discrimination, and joblessness.”⁴⁴ Thus the Lutheran tradition recognizes that social ethics and justice are crucial elements in the provisions of health care and that there will never be health or the right distribution of health care in the world without justice. “Questions of employment, of economics, of distribution of resources, of war and peace, of participation in society must all be addressed in order to address the issues of health and health care.”⁴⁵

The Anglican (Episcopalian) tradition also embodies an understanding of social justice. The 1973 report of their Joint Commission on the Church in Human Affairs enumerated common threads running through their deliberations on health and medicine in contemporary society. These common threads include, but are not limited to, an “insistence upon the worth and dignity of human existence, the right of each individual to exercise choice in issues determining life and death, and the assurance that each person shall ‘be guaranteed the right of survival and the right of protection from attack by others’.”⁴⁶ The right of survival includes the provision of adequate nutritional levels as

⁴⁴ Carter Lindberg, "The Lutheran Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Tradition*, ed. Ronald L. Numbers and Darrel W. Amundsen (Baltimore, MD: The John Hopkins University Press, 1986), p. 192.

⁴⁵ Lindberg, "The Lutheran Tradition," p. 198.

⁴⁶ John E. Booty, "The Anglican Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen (Baltimore, MD: The John Hopkins University Press, 1986), p. 265.

well as other basic necessities, for example, shelter and clothing. The right of protection from attack by others includes high quality medical care for protection against disease or disability.

Although all or nearly all religious traditions embody some understanding of social ethics, many have not reached consensus on social justice or have not articulated that consensus. Thus, this chapter has emphasized an understanding of social justice embodied in the Jewish and Catholic traditions because these traditions have developed and articulated their beliefs, teachings, and values for over a millennium. Their traditions are “out there” and readily accessible. Longevity and praxis thus lend credibility and authority to Jewish and Catholic traditions and teachings. Furthermore, unlike many other religious traditions, Catholicism has an authoritative body to speak for the tradition.

B. Social Justice and Secular Political Philosophy

If social justice can be considered the relationship of the individual person to society, then what constitutes society? How did any society come to be: what theory directs and informs the construction of a society? If it is in the individual’s best interest to form a society, then how should that society be structured in order to achieve social justice?

Social contract theory, nearly as old as philosophy itself, is the view that persons enter into a contract, implied or hypothetical, to form a society, and that their rights and duties, their moral and political obligations, derive from this contract. Although certain Socratic arguments anticipate the social contract, the theory itself is associated with modern moral and political theorists, specifically Thomas Hobbes, John Locke, and Jean-Jacques Rousseau. Social contract theory became one of the most dominant theories

within moral and political theory throughout the history of modern western thought but then became dormant for some time. In the twentieth century, however, social contract theory regained philosophical momentum.

John Rawls, drawing on the utilitarian insights of Jeremy Bentham and John Stuart Mill, the social contract ideas of John Locke, and the categorical imperative ideas of Immanuel Kant, developed a theory of justice that has come to be known as justice as fairness. Rawls proposed that each individual person “possesses an inviolability founded on justice⁴⁷ that even the welfare of society cannot override [and] for this reason justice denies that the loss of freedom for some is made right by a greater good shared by others.”⁴⁸

Rawls formulates the principles for his theory of social justice by imagining individual persons in a hypothetical situation called the original position, covered by a veil of ignorance. In this original position limited by the veil of ignorance, individuals can discover both the nature of justice and also what justice requires of each individual and of the social institutions through which individuals live together cooperatively in society.

In the original position, behind the veil of ignorance, each individual is denied any knowledge of his or her own circumstances, such as age, gender, race, talents, disabilities, health, wealth, or social status. No one knows anything about the state of the society in which s/he lives. Under these conditions, individuals can choose or discover

⁴⁷ This inviolability of the individual person can be thought of as analogous to the primacy of innate human dignity as espoused by the social justice thought of various religious traditions.

⁴⁸ Rawls, *Theory of Justice*, p. 3.

principles for a just society because they are starting from initial conditions that are inherently fair. Because no one has any of the knowledge that makes for and sustains prejudices, the principles chosen from the perspective of the original position behind the veil of ignorance are necessarily fair. Enlightened self-interest will prevent choosing principles that are in any way biased because each individual, once the veil of ignorance is lifted, might find him- or her self at the losing end of such principles. Rawls describes his theory as “justice as fairness,” because the conditions under which the principles are discovered are basically fair. Thus, justice proceeds out of fairness.

According to Rawls, individual persons in the original position, behind the veil of ignorance, would formulate two principles to regulate society at the most basic level, prior even to a constitution. These two principles of justice determine the distribution of both civil liberties and social and economic goods. The first principle of Justice as Fairness states that each individual in a society is to have as much basic liberty as possible, as long as every other individual has equal basic liberty. Thus, there will be as much civil liberty as possible, distributed equally to each individual in the society. The second principle of Justice as Fairness addresses social and economic inequalities in two ways, first as a principle of fair equality of opportunity and second as the Difference Principle. The principle of fair equality of opportunity, the first part of Rawls’s second principle of Justice as Fairness, states that, although social and economic inequalities will undoubtedly exist, these inequalities can be just, as long as opportunities to obtain social and economic goods are available to everyone equally. The Difference Principle, the second part of Rawls’s second principle of Justice as Fairness, states that inequalities

must be arranged so that they are to the advantage of all but especially to the advantage of the least well off in society.

These two principles of justice as fairness relate to each other in a specific order. The first principle, distributing civil liberties as widely as possible consistent with equality, is, and must be, prior to the second principle, governing the distribution of social and economic goods. The demands of the first principle must be satisfied before moving on to the second principle.

The Rawlsian theory of justice as fairness is a highly abstract version of a social contract theory. Rawls does not demonstrate that individuals either would sign or have signed a contract to establish society. Instead, Rawls defined and described what individuals must be willing to accept as rational persons in order to be constrained by justice and therefore capable of living in a well-ordered just society. The principles of justice as fairness are more fundamental than the traditional social contract. Rather, the principles of justice as fairness constrain the traditional social contract and set out the limits of how society can be constructed with equal liberty for all and a fair distribution of economic and social goods.

Thus, John Rawls, arguably one of the most influential political philosophers⁴⁹ of the twentieth century, defines social justice as “justice as fairness.” This theory of justice articulates a primary principle of liberty followed by a two-part principle of democratic equality. The primary principle of liberty specifies equal (civil) liberty for all. The secondary principle of democratic equality governs the distribution of economic and

⁴⁹ Many agree with or espouse Rawls’ theory but many disagree as well. However, the Rawlsian theory allows for application to health care reform, and thus is compatible with the thesis of this dissertation. An exploration of multiple theories of social justice is beyond the scope of this dissertation.

social goods such that equal opportunity to obtain economic and social goods must be open to all and inequalities must be to the advantage of all. Since a just society provides not only equal liberty but also a fair distribution of social and economic goods, it is appropriate at this time to develop an understanding of distributive justice.

IV. Distributive Justice

Distributive justice concerns what is just or right with regard to the allocation of goods, usually focusing on but not limited to economic and social goods, in a society. Principles of distributive justice are normative principles designed to guide the allocation of the benefits and burdens⁵⁰ of economic activity in a society. These distributive principles vary according to what is being distributed, to whom, and on what basis distribution is being made. Throughout most of history, distributive justice was not a topic of discussion because people were born into and remained in a fairly rigid economic position. The distribution of economic burdens and benefits was considered to be fixed, either by nature or by God. More recently, however, when it was realized that government could affect the distribution of economic and social benefits and burdens, distributive justice became an important topic of discussion. Every society faces choices on the distribution of burdens and benefits, considering whether to stay with current laws and policies or to change some or all of them. Distributive justice theory contributes practical guidance in making these decisions. Thus, distributive justice theory is a practical enterprise, not an academic exercise in ideal theory.

⁵⁰ Economic status, economic activity, and comparable terminology encompass all the social and economic goods governed by distributive justice. Thus, economic status is a shorthand notation for necessities, such as food, shelter, and clothing, as well as for education, health care, employment, etc.

Economics, although important in providing information regarding the effects of pursuing various policies, cannot decide what policy changes a society should make. The normative principles of distributive justice, however, in conjunction with economic insight, can recommend which policy a society should pursue.

A. Theories of Distributive Justice

1. Libertarianism

General theories of justice all contain “general principles governing the distribution of rights, opportunities, and wealth.”⁵¹ A libertarian theory of justice, for example the theory advanced by Robert Nozick, a major contemporary libertarian philosopher, advocates a form of “procedural justice with three and only three principles: justice in acquisition, justice in transfer, and justice in rectification.”⁵² He proposes a three-part theory known as the Entitlement Theory:

1. A person who acquires a holding in accordance with the principle of justice in acquisition is entitled to that holding.
2. A person who acquires a holding in accordance with the principle of justice in transfer, from someone else entitled to the holding, is entitled to the holding.
3. No one is entitled to a holding except by (repeated) applications of 1 and 2.⁵³

⁵¹ Norman Daniels, *Just Health Care* (Cambridge, UK and New York, NY: Cambridge University Press, 2001), p. 9.

⁵² Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Fifth Edition (Oxford, UK and New York, NY: Oxford University Press, 2001), p. 232.

⁵³ While the principle of justice in transfer may be acceptable, the principle of justice in acquisition is controversial because Nozick does not clarify how property was initially acquired. See Robert Nozick, “Distributive Justice,” from *Anarchy, State, and Utopia*, in *Justice*, ed. Jonathan Westphal, Hackett: Readings in Philosophy (Indianapolis, IN: Hackett Publishing Company, Inc., 1996), pp. 9-11.

Nozick argues that a theory of justice should affirm individual rights rather than create patterns of distribution or redistribution of wealth acquired under a free market economic system. In essence, then, libertarian theories do not really recognize distributive justice but instead advocate principles based on the just acquisition and just transfer of property. Thus, a distribution is just as long as everyone is entitled to the property they possess.

2. Utilitarianism

An alternative to libertarianism is utilitarianism, a theory closely associated with welfare-based principles of distributive justice. Utilitarians argue that a just distribution is one that realizes the “greatest possible amount of good, the least possible amount of bad, or the best possible ratio of good to bad.”⁵⁴ Thus, under a utilitarian theory of distributive justice, moral worth or justice is determined by outcome.

3. Egalitarianism: Strict

Strict egalitarianism, a second alternative to libertarianism, is a theory that holds that persons should receive an equal distribution of the burdens and benefits of society. This theory is predicated on the claim that as persons we are fundamentally equal, with equal basic rights. Thus, if all persons have equal moral standing, then all have the right to be “respected by others and to develop a proper sense of self-respect...a right to equality of opportunity...[and] an equal right to a reasonable share of basic goods and service necessary for a decent human life.”⁵⁵ However, strict egalitarianism is difficult if

⁵⁴ Charles J. Dougherty, *American Health Care: Realities, Rights, and Reforms* (New York, NY: Oxford University Press, 1988), p. 35.

⁵⁵ Dougherty, *American Health Care*, p. 55.

not impossible to apply in the real world because persons have unequal needs and unequal accomplishments. Strict egalitarianism simply does not fit into the empirical world of practical inequalities.

4. Egalitarianism: Qualified

Qualified egalitarianism,⁵⁶ however, a theory of distributive justice that requires only “some basic equalities among individuals and permits inequalities that redound to the benefit of the least advantaged”⁵⁷ may be an acceptable theory for promoting a just allocation of social and economic goods in a society. John Rawls, the major contemporary example of qualified egalitarianism, argues that a theory of justice must match what we commonly believe to be fair or just with our general principles. Rawls promotes a principle of fair equality of opportunity, a principle that recognizes that society has a positive obligation to eliminate or reduce barriers to fair equality of opportunity, including programs to compensate for or correct various disadvantages.

V. Justice: Theories of Distributive Justice and Health Care

John Rawls, in *A Theory of Justice* and later works, limited his discussion to the theoretical level and did not pursue the application of his theory to practical situations or the implications of his theory for practical social problems such as health care. Other philosophers, however, have interpreted and extended the theory proposed by Rawls to real social problems, such as health care. Norman Daniels, for example, argues for a “just health care system based on ‘fair equality of opportunity,’ relying implicitly on the

⁵⁶ Qualified egalitarianism is also known as contractarianism.

⁵⁷ Beauchamp and James F. Childress, *Principles of Biomedical Ethics, Fifth Edition*, pp. 233-4.

importance of health care needs and a considered judgment that fair opportunity is central to any acceptable theory of justice.”⁵⁸

One further aspect of the Rawlsian theory, the difference principle, must be included because it is both a logical progression from the preceding discussion and a prelude to the discussion to be developed in the following chapter. The Difference Principle states that, although inequalities are inevitable and perhaps even desirable in a society, in order to be just and fair these inequalities must work to the advantage of the least well off. Rawls “couples the fair equality of opportunity principle with the difference principle and calls the combination ‘democratic equality’.”⁵⁹ The difference principle is much stronger than a trickle down of gains from inequality. Rather, “the difference principle softens the effects of the social and natural lotteries by requiring a maximal flow downward, [thus ensuring] that the basic structure works to the advantage of all.”⁶⁰

Having looked at various theories of distributive justice, it appears clear that distributive justice theory is a practical enterprise. Therefore, it is appropriate to proceed to a discussion of justice in the applied or practical sense.

VI. Justice: A Summary

To be fully human is to be social and to live in community with one another. Thus, to live in society is to cooperate fairly with each other according to the principles that inform and govern what we owe to one another as members of a society, the

⁵⁸ Beauchamp and James F. Childress, *Principles of Biomedical Ethics, Fifth Edition*, p. 234.

⁵⁹ Daniels, *Just Health*, p. 53.

⁶⁰ Daniels, *Just Health*, p. 54.

principles of social justice. Principles of social justice, such as those developed or formulated by John Rawls in his theory of justice as fairness, govern and guide society to grant to each individual full and equal liberty and to distribute the burdens and benefits of society fairly in accordance with the principles of distributive justice.

Principles of distributive justice are normative principles designed to guide the allocation of the benefits and burdens in a society. Distributive justice, thus, concerns what is just or right with regard to the allocation of goods, economic and social, among the members of a society.

These two, then, — social justice and distributive justice — in concert and working together, provide an understanding of practical justice. Practical justice is applied justice, wherein the principles of justice in theory are applied to practical, concrete situations and problems.

Theoretical justice, that is, an understanding of justice at the theoretical level, provides us with normative principles that tell us what justice means, at the conceptual level and also in society as social justice and in the fair distribution of the burdens and benefits of society in distributive justice. When we apply this theoretical knowledge and understanding to society and to the problems faced by a fair and just society, we begin to develop an understanding of a practical sense of justice.

Thus, having developed an understanding of justice at the theoretical level, including a basic understanding of social justice and distributive justice, it is now appropriate to apply this understanding to the practical problems associated with the American health care system. Chapter Two will examine Justice in the practical sense, working from ideas developed by Daniels and others to construct a framework of

considerations for reforming American health care. The discussion in Chapter Two will proceed based on the assumption that reform is in order because the current American health care system, measured according to the principles of social justice, that is, justice as fairness, and the principles of distributive justice, including the terms of fair cooperation and the difference principle, is unfair. The principles of social justice and distributive justice are not being honored under the current American health care system and therefore the system is unjust. And if the current American health care system is unjust, then justice demands that the system be reformed.

Scholars and others have discussed and written extensively about the American health care system and whether and why it should be reformed. They rarely invoke the same theories of justice to support their arguments. Wikler argues that members of the President's Commission⁶¹ discussed several moral theories in regard to access to health care, provided different accounts of equity in access to health care and insisted that rival theories are mistaken but were still able to reach consensus. One policy recommendation is clear, that "every person ought to be assured of access to some decent minimum of health care services."⁶² This recommendation follows from disparate sets of premises and thus suggests that the recommendation is insensitive to choice of moral theory. Wikler reflects overlapping consensus arguing that the members of the President's Commission reached consensus concerning the moral obligation of our society to ensure access to health care for its entire people and this consensus aligns with the thin

⁶¹ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

⁶² Wikler, "Access to Health Care," p. 148.

understanding of justice and the locus of certitude discussed earlier in this chapter. Even if we do not agree on moral theory and thus cannot provide foundational proof that all should have access to a decent minimum of health care, there is still reasonable and even compelling evidence, based on a thin concept of justice and the locus of certitude, that guaranteeing access is the right and just thing to do.

Thus, at the level of theory, there is disagreement about why the American health care system should be reformed, but at the level of a practical recommendation that change is necessary there is agreement. The consideration of justice at the theoretical level, focusing on whether or why the American health care system should be reformed, indicates that change — reform — is in order. The discussion now proceeds to the application of various theories of justice to the work of reform, focusing on how reform could be accomplished and addressing some or all of the factors to be considered in formulating health care policy. Chapter Two will focus on applying theories of justice, social and distributive, to the practical problems of reforming the American health care system to ensure access for all Americans.

Chapter Two:

Justice: In Practice, Applied to Health and Health Care

I. Introduction

The thesis of this dissertation is that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have not succeeded. Chapter Two will develop this thesis by moving from a theoretical understanding of justice that supports a moral right to health care to applying theories to the practical problems of developing a just or more just health care system for Americans. Chapter Two will examine the works of several scholars in the field, analyze their arguments, and argue that their work supports a moral right to health care on several bases but that it takes more than a moral right to accomplish reform in the practical sense.

Justice, the first virtue of social institutions, defines and informs how we treat one another as members of a society. Our ideas and beliefs about what we owe to each other derive in some measure from how we want to be treated. We owe and must give to others what we want them to give to us.⁶³ This has specific application to and implications for health care reform.

⁶³ This practical understanding of justice derives from the Golden Rule, a tenet espoused by all or nearly all world religions. Simply stated, the Golden Rule teaches that we must do unto others as we would have them do unto us. In secular terms, the Golden Rule becomes the Ethic of Reciprocity.

Thus, we understand⁶⁴ that we cannot expect to be treated fairly if others are not treated fairly. We recognize injustice or unfair treatment when it is done to others and fear that we, too, can expect injustice and unfair treatment unless we act to redress the unjust treatment of others. Common sense, or some other motivating factor, tells us to ensure justice and fair treatment for others so that we can thereby obtain justice and fair treatment for ourselves.

If an understanding of justice at the theoretical level tells us what we owe one another as members of the global community of all humankind and the local community of all Americans, then how do we apply that theoretical understanding of justice to the practical issues of health, health care, and health care reform? What factors must be considered, what questions asked and answered, and what conflicts raised and resolved in order to develop a just, or more just, health care system for all Americans?

An understanding of justice both in theory and in the application of theory to the practical issues related to health and health care is important to the development of the thesis of this dissertation, that a social reform movement should be promoted and might be necessary in order to effect comprehensive reform of the American health care system. Reform is necessary because the American health care system as currently structured is unfair. A social reform movement may be necessary because the effort to accomplish reform through the political and legislative processes have failed.

⁶⁴ This understanding may be intuitive, that is, it may be related to our ability to sense or know immediately without reasoning. Immanuel Kant, however, refers to practical reason, the reason we use in deciding how to act. Practical reason is connected to *a priori* moral knowledge of how we ought to act. We also understand justice and fairness, in relation both how we are treat others and how others are to treat us, from the teachings of the many religions that derive their teachings from revelation.

A. Scope of Part One

Part One of this dissertation, Justice, develops an understanding of justice at the theoretical level that may be acceptable to all or nearly all Americans and applies this theoretical understanding to the practical problems of health and health care. The theoretical understanding of justice supports a moral right to health and health care that is a corollary of our “social obligation to ensure fair equality of opportunity [and] promote normal functioning and is tied to the terms of fair cooperation that are justifiable within a society of free and equal individuals.”⁶⁵ It is beyond the scope of this dissertation to develop a philosophical foundation for a right to health care, if in fact it would be possible to develop such a foundation. Furthermore, developing, demonstrating, or proving a proper philosophical foundation for human rights in general and a right to health and health care in particular will not help in setting the priorities and resolving the conflicts that must be set and resolved in any health care system. However, a moral right to health and health care that derives from social obligations and the terms of fair cooperation within a just society should be an adequate basis for arguing that the American health care system as it is currently structured is unjust and therefore must be reformed.

B. Recap of Chapter One

Chapter One of this dissertation developed an understanding of justice at the theoretical level and examined justice as a philosophical concept, as social justice, and as distributive justice. Chapter One also discussed a minimal or thin understanding of

⁶⁵ Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York, NY: Cambridge University Press, 2008), pp. 316-17.

justice grounded in common experiences and introduced the locus of certitude, the idea that we can agree on what is the right thing to do even if we disagree about the reasons for doing it.

If all or nearly all agree that every person should have access to at least a decent minimum of health care, then the focus shifts and the discussion moves on to how this can be accomplished. The work of determining how universal access to at least a decent minimum of health care can be accomplished involves moving from a theoretical understanding of justice to a practical understanding of how these theories apply, in part or in whole, to health care and health care policy. The focus of Chapter Two will be to examine some of the ideas and arguments that have been developed in regard to meeting health needs fairly. Justice may inform our behavior, but there are practical considerations governing how we put justice into practice. This is the focus of Chapter Two, to explore the issues related to applying theories of justice to the practical problems of health and health care in order to answer some of the practical questions that must be answered,

C. Scope of Chapter Two

Chapter Two will develop the thesis by first examining the work of several scholars, Daniel Wikler, Norman Daniels, Madison Powers and Ruth Faden, and Erich H. Loewy and Roberta Springer Loewy, who have written extensively on the subject of just health care, and then analyzing the works examined for common threads and points of agreement and divergence. Each of these authors speaks from a different perspective and all speak in general about how a just or more just American health care system might be developed. None of these authors proposes a specific plan for what the reformed

American health care system should be but all present well-reasoned arguments for the need for reform, introducing the factors that must be considered, asking the questions that must be answered, and raising the conflicts that must be resolved in proposing any health care system or evaluating any health care system proposed by others.

Although it is beyond the scope of this dissertation to suggest what the specifics of a reformed American health care system should be, it must be emphasized that a just health care system must provide universal access to a reasonable set of health care services and must be affordable.⁶⁶ All of the authors whose work will be examined agree that universal access and affordability are fundamental requirements of a just health care system.

However, health care is but one social good among many others and, although health care is certainly an important social good, it is probably not the highest. Access to health care will contribute to well being but it is only one of several factors that determine overall well being. Several of the authors whose works will be examined look beyond access to health care to the wider social context for other factors that greatly influence health and well being. Consideration of other “socially controllable factors” must enter into the discussion of what determines well being.⁶⁷ Furthermore, rights and

⁶⁶ The author of this dissertation favors a well-regulated single-payer system but is too pragmatic to believe that such a system could be endorsed, at least in the foreseeable future.

⁶⁷ In *Just Health*, Norman Daniels uses the term “socially controllable factors” to include such things as housing, education, income, and job security, among other factors that contribute to a person’s well being. In a comparable work, *Social Justice*, Madison Powers and Ruth Faden decry systematic disadvantage and identify six factors as essential dimensions of well being, including health and personal security among others. In a recent article, Erich H. Loewy and Roberta Springer Loewy criticize the socio-economic conditions that condemn more than twenty percent of Americans to live without health insurance and thus without access to regular health care. These same socio-economic conditions force between a quarter and a third of American children to be hungry a significant part of each year, and create uncounted numbers of homeless including many of the elderly whose Social Security benefits are not enough to cover both food and lodging. Hunger and homelessness contribute to poor health and thus to the need for access to health

responsibilities are complementary, and in order to claim rights for oneself, one is obligated, duty-bound, to extend those rights to others. Also, the question of how to allocate resources for important social goods, including health care, under conditions of limited, finite resources must be addressed and resolved.

Since there appears to be consensus that Americans have a moral right to health care, the discussion now moves to an examination of the work of Daniel Wikler, specifically to an essay written for the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

II. Developing a Just Health Care System: Practical Considerations

A. Daniel Wikler

If Americans have a moral right to health and health care, whether grounded in an innate understanding of what we owe one another as members of the general community of all humankind or the particular community of all Americans as set forth in the Golden Rule or Ethic of Reciprocity or in the terms of fair cooperation that are justifiable within a society of free and equal individuals, then focus must turn away from justice at the theoretical level, an understanding of which informs us that we must act to redress injustice and why we must do so, to justice at the practical level to determine how to create a just or more just health care system for all Americans. That is, we must move beyond asking whether or why we should act to asking how we should bring about reform and what specifically we should do to create a just system that honors the moral

care. See Daniels, *Just Health*; Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (New York, NY: Oxford University Press, 2006); Erich H. Loewy and Roberta Springer Loewy, "Framing Issues in Health Care: Do American Ideals Demand Basic Health Care and Other Social Necessities for All?" *Health Care Analysis* 15 (2007): 261-71.

right of all Americans to health and health care. We must examine the many factors that must be considered and find solutions for the many conflicts that must be resolved.

In a 1983 essay written for the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Daniel Wikler develops philosophical perspectives on access to health care and introduces some of the many and varying theories of justice that might be applied to the practical problems of health and access to health care. These theories have been presented and defended by a wide variety of experts, philosophers, and scholars to argue for or to demonstrate a right to health care and to explain why and how justice demands health care for all. Among the experts, philosophers, and scholars, there is little if any agreement about which theory of justice should underlie a moral right to health and health care, that is, which theory of justice best explains why justice demands reform of the American health care system. Yet there is agreement or consensus that all Americans should be guaranteed access to reasonable health care services, despite the lack of agreement or consensus on why this is so.⁶⁸

1. Consensus That Reform Is Necessary

Agreement or consensus that change is needed is certainly desirable and perhaps even necessary to the work of reform, but it is not of itself sufficient to create a health care system that provides universal access to reasonable health care services. There are numerous factors that must be considered and many conflicts that must be resolved in moving from a moral commitment to reform to creating the policy that must underlie the

⁶⁸ This is related to the locus of certitude described in Chapter One of this dissertation. It is possible to agree on what is the right thing to do, even if the underlying reasons for doing the right thing differ. See Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley and Los Angeles, CA: University of California Press, 1988), pp. 16-19 and p. 14.

moral right and Wikler discusses some of these considerations in his essay. What, then, are some of these factors that must be considered and conflicts that must be resolved?

2. Equitable Access: What Is Meant By “Equitable”

Since there appears to be a consensus, at least from the members of the President’s Commission and from many, if not most, Americans as well, that our society has a moral obligation to ensure access to health care for all its people, what is meant by the statement that there must be equitable access to a reasonable set of health services? What, specifically, is meant by “equitable” access? The term “equitable” can be interpreted many ways. To a libertarian,⁶⁹ for example, “a market in which nearly no one could afford to see a doctor could, under certain conditions, be perfectly equitable.”⁷⁰ Equitable could also mean to treat equally unless there are morally relevant differences,

⁶⁹ Libertarians advocate maximum individual liberty and negative rights, that is, rights of noninterference. Robert Nozick, a well-known contemporary advocate of libertarianism, proposes a 3-part Entitlement Theory: a) justice in acquisition; b) justice in transfer; c) justice in rectification. Nozick also qualifies justice in acquisition with the Lockean Proviso, whereby “an exclusive acquisition of the external world is just if, after the acquisition, there is enough [of equivalent value] left for others. Charles Dougherty, however, argues that the structure of ownership in contemporary society is likely to have been tainted by invasions and conquests. In the United States, for example, “original ownership by Native Americans was not individual ownership of the sort envisioned by libertarianism [so that] subsequent ‘original’ personal possession by Europeans was accomplished by force or deception.” Thus, the principle of justice in acquisition is at least suspect. See , 17 June 2009 <<http://plato.stanford.edu/entries/justice-distributive>>; Charles J. Dougherty, *American Health Care: Realities, Rights, and Reforms* (New York, NY: Oxford University Press, 1988), p. 76.

⁷⁰ It should be noted that although libertarians do not recognize access to health care as a matter of justice, they do advocate a principle of beneficence whereby doctors and hospitals may, if they choose, provide health care services to the poor and uninsured as a matter of charity. Citizens may also choose to donate to charities that then provide health care to the poor and uninsured. This principle of beneficence is not, however, obligatory. For quote in body of text, see Daniel Wikler, "Philosophical Perspectives on Access to Health Care: An Introduction," in *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services; Volume Two: Appendices, Sociocultural and Philosophical Studies*, ed. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, DC: U.S. Government Printing Office, 1983), p. 114.

but what, then, constitutes a morally relevant difference?⁷¹ There are also physical, geographical, and other factors that impact on “equitable,” factors such as inequalities in access based on location, that is, whether urban or rural. Age and ability to pay may also be factors. Cost of treatment, prognosis, and prospect of cure or rehabilitation must also be considered in determining what is equitable.

3. Equitable Access: What Is Meant By “Access”

Beyond these considerations in regard to the term “equitable,” a number of factors must also be considered in regard to the term “access.” Access could mean, for example, that doctors and other health care personnel, hospitals, and medical services exist and may be used if one has the necessary means. Access could also mean that people must have the necessary means to acquire existing doctor, hospital, and medical services. Thus, access has at least two interdependent aspects: availability and financing. For a health care system to be just, both must be included. “The existence of medical institutions in the total absence of the funds needed to use them — availability without financing — does not amount to access.”⁷² Thus, in designing a just health care program, consideration must be given to whether to help the poor with their sickness, the sick with their poverty, all who are sick, all who are poor, or all in general. Furthermore, a moral right to health care in any context of scarcity implies a diversion of resources from other social uses and thus there are also priority problems that must be considered.

⁷¹ There is general agreement that such factors as race, gender, sexual orientation, and religion are not morally relevant.

⁷² Wikler, "Access to Health Care," p. 115.

4. Priority Problems: Health Care As One Of Many Social Goods

In fashioning a just health care system, two kinds of priority problems arise: the priority between health care and other individual and social goods, wants and needs, and the priority of the many health services available, what should be included, what omitted, and how to determine what these priorities are.

Health care is an important societal good but it is not the only or even necessarily the most important good. Other societal goods to be considered include education, housing, and the creation and maintenance of a job market sufficient to provide employment to all who are able to work. Thus, careful consideration must be given to the priority of health care as one of the important social goods. Once the priority of health care as an important social good has been established, that is, once it has been decided how much of the nation's resources will be allocated to health care, then decisions must be made regarding how to use those resources because, no matter how generous the allocation for health care, it will not be infinite. Thus, careful consideration must also be given to which of the many available health care services will be included. Since it will not be possible to provide every available form of therapy and treatment, there must be a mechanism or procedure for deciding which health care services to include and which to omit.

5. Priority Problems: Which Health Care Services To Include

It is an inescapable though unwelcome fact that, in the context of limited resources, a just health care system will provide some services and omit others. Even the most generous set of health care benefits cannot and will not include all available health care services. Therefore, an important first step toward establishing moral priorities in

regard to which services to include in a just health care system might be to define health and thus set boundaries around the classes of health care benefits to be included.⁷³ The meaning of health varies from a broad definition equating health with overall well being to a narrow focus on “absence of deviation from species-typical functioning.”⁷⁴ so that a reasonable definition might lie between these two extremes.

6. Priority Problems: Specifying Principles For Choosing Health Care Services

Another consideration, a philosophical task, is to specify the principles for choosing health services. Will the criteria be subjective or objective? Will health services be decided according to wants or needs? If a right to health care is a right to have desires for health services met, then setting priorities becomes an individual choice. But if, in the more likely case considering limited resources, the entitlement to health care is based on having needs met, then there must be a rational plan for making choices and setting priorities.

Defining basic terms such as equitable access and setting priorities both for health care as only one of many social goods and for choosing which services to include in a just health care system are two of the many factors to be considered, questions to be answered, and conflicts to be resolved in developing a just health care system. Wikler addresses many of these factors, questions, and conflicts in his essay for the President’s Commission.

⁷³ It might be thought that the criterion for determining what services should have the highest priority should be the specific needs of an individual patient. However, for a health care system, decisions must be made and priorities set on a global basis with provision for addressing special needs on an individual basis and overriding global decisions if and as necessary.

⁷⁴ Wikler, "Access to Health Care," p. 118.

Norman Daniels, in his most recent book, *Just Health: Meeting Health Needs Fairly*, shifts the focus from the health care system in isolation from other social factors and examines health in the context of a just society. He refocuses some of the questions and suggests methods of determining whether a proposed health care system is in fact just and fair. Daniels moves beyond access to health care as the sole determinant of health and begins to examine other important determinants of health.

B. Norman Daniels

Daniels bases his discussion of just health and health care on the terms of fair cooperation that are justifiable within a society of free and equal individuals, what citizens owe to one another as members of a just society. He does not couch the issue in terms of whether health care is a right. Invoking a right to health care raises philosophical questions that tend to obscure the issue rather than elucidate it. Furthermore, invoking a right to health care or attempting to demonstrate that such a right exists, does not help in any practical sense to answer the questions and resolve the conflicts that must be answered and resolved in creating a just health care system.

In *Just Health*,⁷⁵ Daniels sets out “to present an integrated theory of justice, to address a set of theoretical and real world challenges to that theory, and to demonstrate that the theory can guide our practice with regard to health” and health care.⁷⁶ Thus, a theory of justice must tell us what we owe one another in the promotion and protection of health by explaining the moral importance of health, by telling us when differences in

⁷⁵ *Just Health* is the result of the many encounters Daniels has had with the practical challenges of working towards just health and health care in the real world.

⁷⁶ Daniels, *Just Health*, p. 1.

health are unjust, and by guiding our thinking about meeting health needs fairly when we cannot meet all of them.

Daniels begins his exploration of just health and just health care by posing a fundamental question about our social obligations to promote and protect health and to assist those who are ill or disabled. He begins to answer his fundamental question by substituting three more specific focal questions: first, is health, and therefore health care, of special moral priority; second, when are health inequalities unjust; and third, how can we meet health needs fairly under resource constraints?

1. Special Moral Priority of Health

In answering his own three focal questions, Daniels draws upon the work of John Rawls, arguably the most influential political philosopher of the twentieth century, and argues that a socially just society is concerned with providing fair equality of opportunity⁷⁷ for its members. This connection with Rawls' theory of justice as fairness correlates directly with the answer to the first focal question: health is of special moral importance because it contributes to the range of opportunities open to us. Thus, accepting the Rawlsian view that justice as fairness demands that society must promote and protect fair equality of opportunity for all means that protecting health is a social obligation. "As members of a society seeking fair terms of cooperation to protect each

⁷⁷ The importance of protecting fair equality of opportunity is supported by many general theories of justice in addition to Rawls' theory of justice as fairness. The capabilities approach developed by Sen and Nussbaum and the "appeal to equal opportunity for welfare or advantage" advocated by Arneson and Cohen are two alternative theories to Rawls that still support the importance of protecting fair equality of opportunity. See Daniels, *Just Health*, pp. 63-77.

other's health, we owe it to each other to design institutions”⁷⁸ to provide the necessary protection.

2. Unjust Health Inequalities

This answer to the first focal question leads to the consideration of the second focal question regarding when health inequalities are unjust. In answering this question, Daniels moves beyond the idea that access to health care is the sole or even the most important determinant of good health and fair equality of opportunity to a discussion of various socioeconomic factors that directly influence good health and fair equality of opportunity. There are many socially controllable factors, such as education, income, wealth, housing, and job security, as well as access to health care, that affect health and health inequalities.⁷⁹

When health care is included in the institutions that protect opportunity, then the general principles of Rawls' justice as fairness capture the key social determinants of health. Thus, justice as fairness in theory leads to a fair distribution of the social determinants of health. If, however, justice as fairness is not put into practice, then the social determinants of health may not be fairly distributed and health inequalities may result. The existence of health inequalities is an indication that the social determinants of health are not fairly distributed. Thus, health inequalities are unjust when they derive from an unjust distribution of the socially controllable factors that affect population health and its distribution. Protecting health and promoting fair equality of opportunity requires more than merely providing access to health care. To understand when health

⁷⁸ Daniels, *Just Health*, p. 27.

⁷⁹ In the United States, there are still significant racial inequalities in life expectancy and morbidity.

inequalities are unjust, we must not only understand the socially controllable factors that affect population health and its distribution, but also recognize when the distribution of these socially controllable factors is not fair or just.

3. Meeting Health Needs Fairly Under Resource Constraints

Having developed the argument that health (and therefore health care) is of special moral importance because it protects and promotes fair equality of opportunity and that health inequalities are unjust when they result from an unjust distribution of the socially controllable factors that contribute to good health, Daniels turns to the third of his three focal questions and asks how to meet health needs fairly with limited resources.⁸⁰ No matter how much we agree about the moral importance of health, or which health inequalities are unjust, or even what resources should be dedicated to health and health care, all this agreement still does not provide specific answers on how to set priorities and how to meet conflicting needs fairly when all needs cannot be met. How can we fairly decide which needs have priority over other needs?

The problem of resolving these conflicts arises because of lack of consensus on specific principles to invoke. A general principle, such as Rawls's principle of fair equality of opportunity, provides an adequate basis for our social obligation to promote health but is too general to guide specific resource allocation decisions. Since we do not agree on principles for resolving disputes, Daniels appeals to procedural justice and proposes reliance on a fair deliberative process to resolve disagreements about resource

⁸⁰ The issue of determining how to meet health needs fairly with limited resources is not central to the thesis of this dissertation but the question must be addressed in the real world of health care reform. Very recently (June 2009), President Obama's health care reform initiative campaign began in earnest and questions about what will be included and who will decide were raised at the beginning and have been raised repeatedly nearly every day since the kickoff. This is a very serious issue that needs to be resolved.

allocation. This fair deliberative process would supplement guidance from general principles.⁸¹

4. How We Should Think About Health And Health Care

Daniels's three focal questions and answers have a direct bearing on how we should think about health and health care for all. Meeting the health needs of all is of special moral importance because it protects the range of opportunities of all people. Our social obligations to protect and promote opportunity include the obligations to protect and promote health for all. Just health requires that we protect each person's share of the normal opportunity range by "treating illness when it occurs, by reducing the risks of disease and disability before they occur, and by distributing those risks equitably."⁸² This means giving all people access to services that promote and restore normal functioning without neglecting preventive measures in favor of curative measures, looking beyond the health care system to traditional public health and safety measures, and looking beyond the health care sector to the broader social determinants of health. Furthermore, because we cannot meet all health needs, we must establish a fair deliberative process for resolving conflicts and allocating resources and be accountable for the reasonableness of the resource allocation decisions. To meet our social obligations to protect and promote fair equality of opportunity by protecting and promoting health, we must design appropriate policies both within and without the health sector. The answers to the three focal questions help to clarify our obligations to one another and to establish priorities

⁸¹ For an expanded discussion of procedural justice and a fair deliberative process to resolve disagreements about resource allocation, see Daniels, *Just Health*, Chapter 4.

⁸² Daniels, *Just Health*, p. 141.

among the many health services available, giving priority to treatment over enhancement and holding people accountable in reasonable ways for their behaviors. Thus, Daniels's integrated theory of just health "coheres and gives general guidance to major policy issues."⁸³

5. Benchmarks Of Fairness

In discussing fairness in health sector reform, Daniels refers repeatedly to the *Benchmarks of Fairness for Health Care Reform*,⁸⁴ an earlier work written in collaboration with Donald Light and Ronald Caplan. *Benchmarks of Fairness* describes a tool or a methodology for monitoring and evaluating the fairness of any proposed health care reform. "The benchmarks of fairness take a general position about values, philosophy, and the just society and translate them into ten specific benchmarks and thirty-one detailed criteria that provide a moral framework for anyone doing health care reform."⁸⁵ In describing the ten benchmarks and then applying them to four actual, national scale proposals from the early 1990s,⁸⁶ the authors point out and reiterate that there is nothing inherently unjust or unfair about any particular proposed health care reform plan. Proposals become more or less unfair or unjust according to the detailed provisions in the bill. Thus, fairness and justice must be an integral part of the policy

⁸³ Daniels, *Just Health*, p. 158.

⁸⁴ Norman Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness for Health Care Reform* (New York, NY: Oxford University Press, 1996).

⁸⁵ Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness*, p. 129.

⁸⁶ *Benchmarks of Fairness* evaluates four bills from the 103rd Congress: the Michel bill, "Affordable Health Care Now;" the Cooper bill, the "Managed Competition Act;" the Clinton bill, the "Health Security Act;" and the McDermott-Wellstone bill, the "American Health Security Act." See Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness*, Chapter Four.

development and legislative process. The fairness of any proposal must be developed alongside the affordability and feasibility of the proposal.

Daniels's coherent and integrated theory of just health in conjunction with the detailed analyses included in the benchmarks of fairness present a strong argument for the necessity of reforming the American health care system, a system that Daniels, Light, and Caplan describe as "the most unfair health care system in the industrialized world."⁸⁷ No other industrialized nation fails to guarantee universal access to health care or allows coverage or premiums to vary by risk or health condition. No other industrialized nation forces those who earn less to pay proportionately more of their take-home pay for health insurance than those who earn more. No other nation comes close to being as inefficient as the American system.⁸⁸

Thus, the American health care system needs to be reformed but there is more to good health than access to health care. Daniels refers to but does not expand on the socially controllable factors that affect health and therefore fair equality of opportunity. In *Social Justice*,⁸⁹ Madison Powers and Ruth Faden explore in more depth these socially controllable factors.

C. Powers and Faden

Whereas Daniels uses Rawls's theory of justice as fairness, augmented by adding health care to the institutions that protect and promote fair equality of opportunity, as the

⁸⁷ Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness*, p. 74.

⁸⁸ Nearly a quarter of all insurance premiums go to administrative overhead, marketing, and profits. See Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness*, p. 74.

⁸⁹ Powers and Faden, *Social Justice*.

basis for his integrated theory of just health, Powers and Faden refer to the Rawlsian approach as an ideal theory that does not and was not meant to address issues of justice in the practical, concrete sense then quickly diverge from Rawls to develop their own nonideal theory of social justice. Powers and Faden start not with an ideal set of distributive principles presumed to be acceptable to all, but rather with the assumption that the best justified set of distributive principles can only be ascertained with a detailed account of the ends of the underlying human actions. They further assume that the empirical judgments of how various inequalities affect one another are essential moral data. Unjust inequalities provide the real world context for resolving questions of justice because achieving justice is essentially a remedial task that requires constant monitoring and adjusting. “Justice is not a matter of conforming society to an antecedently identifiable set of distributive principles, but rather is a task requiring vigilance and attentiveness to changing impediments to the achievement of enduring dimensions of well being.”⁹⁰ For Powers and Faden, justice must ensure for everyone a sufficient amount of each of the six essential dimensions of well being: health, reasoning, self-determination, attachment, personal security, and respect. These six essential dimensions of well being are different lenses through which justice can be assessed.

1. Six Essential Dimensions Of Well Being

Health, in an ordinary-language understanding of the term, refers to a dimension of human flourishing that includes not only an absence of malfunctioning in biological and organic terms, but also freedom from such impediments as pain, sexual dysfunction

⁹⁰ Powers and Faden, *Social Justice*, p. 5.

and infertility. To be healthy is to be regarded as a moral equal, deserving of respect. So understood, health reflects a moral concern with human flourishing and is thus a morally independent dimension of overall well being and social justice. Because of this moral dimension to health, society has an obligation to ensure universal access to medical care. This societal obligation “rests not only on the effects of access on health but also on what justice requires with regard to what is necessary for being respected as a moral equal.”⁹¹

Personal security is the second of the six essential dimensions of well being. Fear is an impediment to living as a moral equal worthy of respect.⁹²

Reasoning, the third of the six essential dimensions of well being, refers to a broad set of diverse skills and abilities including those that aid us in answering empirical questions and understanding the world around us as well as those that aid us in deciding what we ought to do and how we ought to live. Without reasoning capabilities it is difficult if not impossible to develop critical faculties and independent judgment.⁹³

⁹¹ Powers and Faden, *Social Justice*, p. 18.

⁹² Injustices such as those involving assault, degradation, enslavement, or rape violate any minimal notion of respect for persons as moral equals and instead treat them as having no moral significance at all. “It is extremely difficult if not impossible to live a decent life if one is in constant fear of physical or psychological abuse.” Powers and Faden, *Social Justice*, p. 19.

⁹³ The development of reasoning abilities depends on an adequate level of biological or organic brain functioning, development that can be affected both *in utero* and in early childhood as well as later in life. Healthy brain function is necessary but not sufficient for reasoning because reasoning abilities require an understanding of the world that must be learned by access to education. “Without the knowledge gained through education, it is difficult if not impossible to exercise the capabilities of reason.” Powers and Faden, *Social Justice*, p. 21.

Respect, the fourth essential dimension of well being, involves identifying with others as independent sources of moral worth and treating them as dignified moral beings deserving of equal moral concern.⁹⁴

Forming bonds of attachment is one of the most central dimensions of human well being. These bonds include friendship and love and promote a sense of solidarity with others within the community. If we cannot relate to one another and identify with one another, then we will not be able to extend to one another the just treatment that we want others to extend to us.⁹⁵

Self-determination, the linchpin of liberal political theory, is the ability to shape our lives at least in part by our own choices, informed by our own values and interests. The proper legal, social, and economic structures must all be in place to enable any level of self-determination to be feasible, and certain material conditions are essential as well.⁹⁶

The existence and interaction of these six essential dimensions of well being work “to provide a basis for assessing the justice of the totality of institutions and social

⁹⁴ Respect for others is closely allied with self-respect, the ability to see one’s own self as the moral equal of others, dignified and worthy of respect. Respect helps us to recognize what is owed to each of us, by society and by each other, as independent agents of moral worth entitled to the same just treatment as all other members of the moral community. To respect others is to give to others what we expect, even demand, for ourselves. Thus, respect is closely allied to the Golden Rule and the Ethic of Reciprocity. See Chapter One of this dissertation.

⁹⁵ The bonds of attachment provide a level of emotional engagement and sympathetic identification with others that is essential to the forging of bonds of mutual forbearance and mutual aid and for participating in the responsibilities of caring for one another. These “human capacities for attachment are prerequisite for the formation and perpetuation of a just society.” Powers and Faden, *Social Justice*, p. 24.

⁹⁶ Political liberties are necessary but not sufficient for leading self-determining lives. Thus, legal systems and cultural norms must be structured so as to provide social room for making and implementing meaningful choices. It should also be noted that anyone who is entirely beholden to others for the very means of survival, such as food, shelter, and clothing, is not in any meaningful sense self-determining.

practices”⁹⁷ that make up the basic structure of society. A sufficiency of each of these six dimensions of well being is an important aspect of social justice and a positive aim of Powers and Faden’s nonideal theory of social justice. However, in light of existing inequalities in concrete reality, it is necessary to recognize patterns of systematic disadvantage and compensate for them. Sufficiency depends on more than the distribution of income and wealth. Some priority must be given to those who are worst off to ensure that those who are the least well off have enough.⁹⁸ Inequalities tend to beget inequalities and existing inequalities can “compound, sustain, and reproduce a multitude of deprivations in well being, bringing some persons below the level of sufficiency for more than one dimension. Familiar forms of oppression include ageism, racism, and sexism, but other forms exist as well. Thus, only “when we consider what sufficiency requires in real world concrete circumstances can we say which inequalities are most urgent from the point of view of justice.”⁹⁹

2. Health Care Financing: Market-Based Health Care

Powers and Faden also discuss the implications of their nonideal theory of social justice for the financing of medical care and health insurance, focusing primarily on the American experience of market-based health care. In this discussion, arguably the most specific of *Social Justice*, they reach four conclusions:

First, because of the inherent tendencies of markets to have a systematically disadvantaging impact on well being, the justice of a market system of health care financing depends on the existence of

⁹⁷ Powers and Faden, *Social Justice*, p. 49.

⁹⁸ This idea is not unlike preferential option for the poor. See Chapter One of this dissertation.

⁹⁹ Powers and Faden, *Social Justice*, p. 9.

appropriate background political and economic conditions that can mitigate, rather than compound its potential ill effects;

Second, market-based health care finance under some specific social and economic conditions, especially employer-based insurance arrangements, add to the problems inherent in health care markets and thus pose additional challenges to any efforts to make markets conform to the minimum requirements of justice;

Third, whatever role markets might permissibly play in securing access to health care, justice requires a system of universal, continuous access to a reasonably comprehensive level of medical care; and

Fourth, many currently accepted ways of combining private markets and public safety nets are unjust.¹⁰⁰

Powers and Faden present an interesting argument for including multiple dimensions in any discussion of social justice and their argument is based as much on concrete, real-world experience as on abstract philosophical concepts. Access to health care is necessary in order to promote and protect health, one of the six essential dimensions of well being. The function of access to health care is to improve human well being by improving health and this ought to be done in a way that focuses on the needs of the most disadvantaged. Thus, “society’s obligation to ensure universal access to medical care rests not only on the effects of access on health but also on what justice requires for what is necessary for being respected as a moral equal.”¹⁰¹

Although most of their arguments focus on the general experience, when they turn to consideration of the American health care experience, Powers and Faden reach specific conclusions that social justice demands universal access to reasonably comprehensive

¹⁰⁰ For an expanded discussion of Powers and Faden’s discussion of their nonideal theory as applied to market-based health care, see Powers and Faden, *Social Justice*, p. 11 and Chapter 5.

¹⁰¹ Powers and Faden, *Social Justice*, p. 18.

health care and therefore the American system as currently structured is unjust. In a recent article in *Health Care Analysis*, Erich H. Loewy and Roberta Springer Loewy explore American issues of social justice including health care from the perspective of the foundational documents of the United States.

D. Loewy and Loewy

Loewy and Loewy argue for the necessity of both universal health care and universal free education¹⁰² using a different argument than those made heretofore, one based in the second paragraph of the Declaration of Independence and the Preamble to the Constitution. Their argument is meant to strengthen, not conflict with, arguments previously made by others. The underlying notion of their argument, that universal health care is necessary to fulfill the American ideals of life, liberty, and the pursuit of happiness, and to give meaning to promoting the general welfare, is that “we have obligations beyond non-harm to one another.”¹⁰³ This notion is based on a communitarian rather than a libertarian worldview. Although definitions of a community may vary, a common understanding of the communitarian worldview is that, because we exist in the world we have a set of obligations toward one another and to the community of which we are a part, however it is defined, and the community has obligations to us as individuals. Community is important, even necessary, because no one is born solitary, and the nurture of family and community are integral to survive, thrive, and develop fully

¹⁰² Education, according to Powers and Faden, is a prerequisite for developing reasoning ability and reasoning ability and health are two of their six essential dimensions of overall well being. Thus Loewy and Loewy agree with Powers and Faden, although for different reasons.

¹⁰³ Loewy and Loewy, "Framing Issues in Health Care," p. 263.

as human beings. The libertarian worldview, by contrast, holds that we are individuals and as such have only the obligation not to harm one another.

1. Declaration Of Independence

Loewy and Loewy develop their argument for the necessity of universal health care from the American ideals¹⁰⁴ spelled out in the second paragraph of the Declaration of Independence and codified in the Preamble to the Constitution. They base their arguments on the self-evident truths, obvious to anyone with the power of reason, enumerated in the Declaration of Independence, “that all men are created equal, that they are endowed by their Creator with certain unalienable rights, [and] that among these [rights] are Life, Liberty, and the pursuit of Happiness.”¹⁰⁵ These rights are natural rights, not contingent on the laws, customs, or beliefs of a particular society. Although the Declaration of Independence has symbolic but not legal standing, it does hold up an ideal for the nation and the world. It should be remembered that symbols are not unimportant and ideals are essential as goals.

2. Preamble To The Constitution

The Preamble to the Constitution, however, has both symbolic and legal standing, and it promotes a worldview that is far more communitarian than libertarian. The Preamble clearly states that the purpose of founding the nation was to “form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves

¹⁰⁴ The argument put forth by Loewy and Loewy echoes the arguments raised by the activists who agitated for Abolition and Woman’s Rights ad Suffrage. See Chapters 6 and 7 of this dissertation.

¹⁰⁵ Loewy and Loewy, "Framing Issues in Health Care," p. 263.

and our Posterity.”¹⁰⁶ Loewy and Loewy argue that promoting the general welfare obliges us to prevent general misery and take measures to promote the well being of all, where well being includes health. They further argue that establishing justice connects to health care because the situation in which a few own a large percentage of the wealth and live in opulent luxury while others live in abject poverty is fundamentally unjust and this gap has a detrimental effect on health which should be of concern to all. The lack of universal access to affordable health care and the deplorable social conditions many must endure run counter to and undermine both the ideals enunciated in the Declaration of Independence and the purpose for which this nation was founded as stated in the Preamble to the Constitution.

Loewy and Loewy do not argue that the Declaration of Independence and the Preamble either directly speak to health care or directly affect the physician-patient relationship but that “both directly speak to what [may be called] the ‘framing conditions of medical ethics’ — that is, those aspects of our societal structure and societal institutions which control access to health care or deal with poverty.”¹⁰⁷ Health care ethics has done well in securing basic patient rights but has done little to secure access to health care for all Americans. If the individual in need of health care cannot enter the health care system, then the physician-patient relationship is moot. Bioethics,¹⁰⁸ a field that has a social purpose and therefore should be a leader in promoting a social order in which health care is universally available, has done little in practical terms to improve the

¹⁰⁶ Loewy and Loewy, "Framing Issues in Health Care," p. 271.

¹⁰⁷ Loewy and Loewy, "Framing Issues in Health Care," p. 265.

¹⁰⁸ Daniels, in *Just Health*, also comments on the fact that Bioethics has consistently ignored the social determinants of health. See Daniels, *Just Health*, Chapter 3, pp. 81-82 and 101-02.

lot of the uninsured and underinsured. For these underserved, the ideals of the Declaration of Independence and the promises of the Preamble to the Constitution have not been realized.

Thus Loewy and Loewy, working from a unique perspective, reach the same conclusions as so many others, that the only just health care system is one that provides universal access to reasonably comprehensive health care services and that therefore the American health care system, as currently structured, is fundamentally unjust.

III. Analysis Of Works Examined: Points Of Convergence And Divergence

In terms of both an understanding of justice in the theoretical sense and the application of this theoretical understanding to the practical issues of health and health care, there is consensus that a just health care system is one that provides universal access¹⁰⁹ to reasonably comprehensive health care services. There is not, however, agreement on why this is so or how to achieve such a just health care system in the United States.

This chapter has examined a subset of the work of several scholars in the field,¹¹⁰ all of whom agree that universal access and affordability are fundamental requirements of a just health care system, although they develop their arguments from different perspectives. Wikler and Daniels, for example, argue at the level of ideal theory, Powers and Faden move to nonideal theory, and Loewy and Loewy base their argument on the

¹⁰⁹ In a recent essay, Paul Menzel argues that the focus should be on universal participation, that is, a mandatory system, as the best way to achieve universal access. See Paul T. Menzel, "Justice and Fairness: Mandating Universal Participation," in *Connecting American Values with Health Reform*, ed. Mary Crowley (Garrison, NY: The Hastings Center, 2009), 4-6.

¹¹⁰ The scholars are Daniel Wikler, Norman Daniels, Madison Powers and Ruth Faden, and Erich H. Loewy and Roberta Springer Loewy.

ideals enumerated in the founding documents of the United States. There is also considerable agreement that access to health care is not the only or even necessarily the most important factor in health status and that, therefore, attention must be focused on other socioeconomic factors such as education, decent housing, jobs, and financial security.

1. Wikler

Daniel Wikler considers questions related to a health care system, questions such as access to the system and what health care services to be included, to be of primary importance. He delineates some of the factors that must be considered in developing a just health care system by focusing on some of the terminology that is so high-level that it is virtually content-free. Wikler argues that these factors and terms must be given content that is acceptable to all or nearly all Americans in order to make progress toward developing a just or more just health care system.

2. Daniels

Norman Daniels moves beyond access to the health care system and considers other factors relevant to health, such as socioeconomic status and socially controllable factors, to be at least as important as and probably more important than access to the health care system. He places the burden on all of society and expands the discussion of health care by looking beyond access to health care as the sole determinant of health status and focusing on other socioeconomic factors, such as education, income, wealth, housing, and job security, that affect health status. Daniels does not invoke a right to health care but instead bases his argument on the terms of fair cooperation in a just society. He draws upon John Rawls's theory of justice as fairness but augments it by

adding health care to the institutions that protect fair equality of opportunity, then argues that health and access to health care are of special moral importance because they protect and promote fair equality of opportunity. Daniels also argues that the Benchmarks of Fairness or some other comparable methodology ought to be used to evaluate and monitor any proposed health care reform.

3. Powers and Faden

Powers and Faden make quick reference to Rawls's ideal theory of justice as fairness then quickly diverge to develop their own nonideal theory of social justice. They argue that the best justified set of distributive principles can only be determined with a detailed account of the ends of the underlying human actions, something that cannot be done behind the veil of ignorance. Powers and Faden also argue that empirical judgments of how various inequalities affect one another are essential moral data. Like Daniels,¹¹¹ Powers and Faden move beyond access to health care as the sole determinant of health status and focus on six essential dimensions of well being: health, personal security, reasoning, respect, bonds of attachment, and self-determination. These six essential dimensions of well being are broadly analogous to the socioeconomic factors that Daniels argues affect health status. Powers and Faden speak in general terms most of the time but in discussing the American health care system they are quite specific in arguing that, as currently structured, it is unjust.

¹¹¹ Also like Daniels, Powers and Faden reference the works of Sen and Nussbaum. See Powers and Faden, *Social Justice*, Chapter 2.

4. Loewy and Loewy

Loewy and Loewy move away from theory and argue that the American health care system as currently structured does not live up to the ideals and promises enumerated in America's founding documents. This argument that American ideals are being undermined echoes arguments made by the earliest American social reformers, the activists who agitated for the abolition of slavery and woman's rights and suffrage. Loewy and Loewy base their argument for health care reform on the founding documents of the United States, the Declaration of Independence and the Preamble to the Constitution. They argue that universal health care is necessary in order both to fulfill the American ideals of life, liberty, and the pursuit of happiness and to give substantive meaning to promoting the general welfare. The underlying notion of their argument, that we have positive obligations to help one another over and above the negative obligations not to harm one another, is derived from a communitarian rather than a libertarian worldview. Loewy and Loewy do not argue that the Declaration of Independence and the Preamble to the Constitution either directly speak to health care or directly affect the physician-patient relationship. Rather these documents address the aspects of social structure and social institutions that control access to health care, the framing conditions of medical and health care ethics. They argue that, while health care ethics has done well in securing basic patient rights, it has done little to secure access to health care for all Americans and that patient rights are meaningless for those who do not have access to the health care system. Thus, Loewy and Loewy, arguing from a unique perspective, reach the same conclusion as the others surveyed in this chapter, that the only just health care system is one that provides universal access to reasonably comprehensive health care

services so that the American health care system, as currently structured, is fundamentally unjust.

B. Common Threads And Unifying Factors

1. Overlapping Consensus

The common thread unifying these various perspectives is that the current American health care system is unfair and should be reformed. The underlying reasons differ but the overlapping consensus is the same. This consensus adds weight to the continuing effort to reform the American health care system. If so many scholars in the field, arguing from different perspectives, reach the same conclusion, then arguments supporting a moral right to health care may be independent of a single foundation.

This overlapping consensus based on different reasons coheres with Walzer's thin concept of justice and Jonsen and Toulmin's locus of certitude. We can agree that health care reform is needed without agreeing about why this is so. Agreement, however, is not sufficient to accomplish health care reform. The political will to act is also needed because substantive change can only be achieved through the political and legal processes.

In examining a subset of the work of these scholars in the field, it is clear that each is aware of and builds on the work of other scholars. Each scholar has points of convergence with the other scholars. Wikler and Daniels, for example, both argue in favor of procedural justice, establishing a fair process to determine which services to

include in a health care system. Moving beyond Wikler, Daniels makes specific suggestions on how this fair process may be initiated.¹¹²

2. Social Obligations

Daniels argues for our social obligation to promote and protect health and stresses the importance of improving socially controllable factors in addition to establishing a just health care system. Powers and Faden refer to six essential dimensions of well being, analogous to Daniels's socially controllable factors. They argue that, in addition to ensuring that all have a sufficiency of these essential dimensions of well being, it is also necessary to recognize and correct systematic disadvantages so that those who are least well off should be given extra help. This idea of giving extra help to those who are least well off is analogous to the preferential option for the poor that is an important part of Catholic teaching on social justice.

Powers and Faden also argue beyond what is society's obligation to what justice requires for treatment of moral equals and this relates to the Golden Rule or Ethic of Reciprocity. They also analyze the American health care system as an exemplar of a market-driven system and conclude that it is unjust. This is the same conclusion reached by Daniels, Light, and Caplan who describe the American health care system as the most unjust in the world.¹¹³

¹¹² For an expanded discussion of why fair process is needed and how such a process may be established, see Daniels, *Just Health*, Chapter 4.

¹¹³ See Daniels, Donald W. Light, and Ronald L. Caplan, *Benchmarks of Fairness*. for an expanded discussion of the injustice of the market-driven American health care system. Mary McDonough also argues that a market-driven health care system, without substantial, enforced regulation, cannot be just. See Mary J. McDonough, *Can a Health Care Market Be Moral: A Catholic Vision* (Washington, D.C.: Georgetown University Press, 2007).

Loewy and Loewy use different terminology and argue from a different perspective, but still emphasize the importance of socioeconomic status, socially controllable factors, and the essential dimensions of well being in contributing to health and developing a just health care system.

Daniels and Loewy and Loewy call attention to the fact that Bioethics has ignored the social dimension of health. Although Bioethicists have made impressive progress on protecting and enhancing the individual physician-patient relationship, they have paid little if any attention to the problem of access for all Americans.

Chapter Two has shown that arguments in support of American health care reform can be based on a generally accepted ideal theory of Justice such as Rawls's theory of Justice as Fairness, on a nonideal theory of justice such as that developed by Powers and Faden, or on the foundational documents of American society, the Declaration of Independence and the Preamble to the Constitution. Thus, although there is disagreement about the theoretical foundations of the need for reform, there is or appears to be consensus of opinion that reform is necessary in order to guarantee access to a decent minimum of health care for all Americans.

IV. Is Consensus Sufficient To Support The Need For Health Care Reform?

A. Recap: Part One

Part One of this dissertation has focused on justice, in theory and in practice, examining some of the most widely accepted theories of justice and exploring some of the ideas of scholars in the field who have applied these theories to the practical problems of developing a just or more just health care system for all Americans. Thus, Part One developed an understanding of justice acceptable to all or nearly all Americans, and

argued for a moral right to health care as a corollary of society's obligation to ensure fair equality of opportunity according to the terms of fair cooperation justifiable within a society of free and equal individuals. This understanding of justice was grounded in the Golden Rule or Ethic of Reciprocity. A moral right to health care derives from this understanding of justice.

1. Chapter One

In addition to examining justice as a philosophical concept, Chapter One also examined social justice and distributive justice. Social justice refers to the relationship of the individual and society, what each owes to the other. Distributive justice refers to the principles that guide the allocation of the burdens and benefits of economic activity in a society. Several of the most widely accepted theories of distributive justice were examined in Chapter One: libertarianism, utilitarianism, and egalitarianism, both strict and qualified.

2. Libertarianism

Libertarianism is a specific theory of distributive justice that advocates maximum individual liberty, accepts only negative rights of noninterference, does not recognize a right to health care, and focuses not on public utility but on the operation of fair procedures. Libertarians support a health care system that is privately funded because society may not impose coercive taxation on citizens in order to fund health care. However, there is also a positive, relational aspect of liberty, a "concept that reminds us that the well-being of one individual is not a function of isolation but of context,

community, and mutual interdependency.”¹¹⁴ This positive aspect of liberty supports access to health care because health and health care enable the individual to live a meaningful and worthwhile life, fully enjoying the richness of liberty.

3. Utilitarianism

Utilitarianism, the greatest good for the greatest number, determines moral worth by outcome. Utilitarians argue that a just distribution is one that realizes the “greatest possible amount of good, the least possible amount of bad, or the best possible ratio of good to bad.”¹¹⁵ Thus a utilitarian argument could support access to health care by creating a system that creates an optimum balance of burdens and benefits.

4. Egalitarianism: Strict

Strict egalitarianism, predicated on the claim that persons have intrinsic worth and are fundamentally equal with equal basic rights, argues that persons should receive an equal distribution of the burdens and benefits of society. However, because persons have unequal needs and unequal accomplishments, strict egalitarianism does not fit into the empirical world of practical inequalities. Thus, no prominent egalitarian theory requires equal sharing of society’s burdens and benefits.

5. Egalitarianism: Qualified

Qualified egalitarianism,¹¹⁶ however, “requires only some basic equalities among individuals, and permits inequalities that redound to the benefit of the least

¹¹⁴ Bruce Jennings, "Liberty: Free and Equal," in *Connecting American Values with Health Reform*, ed. Mary Crowley (Garrison, NY: The Hastings Center, 2009), p. 3.

¹¹⁵ Dougherty, *American Health Care*, p. 35.

¹¹⁶ Qualified egalitarianism is also known as contractarianism.

advantaged.”¹¹⁷ John Rawls’s theory of justice as fairness is a prominent example of qualified egalitarianism. Rawls argues for equality in regard to personal liberty and opportunity¹¹⁸ to obtain jobs and offices but permits inequalities in the distribution of social goods so long as the inequalities are to the benefit of the least advantaged members of society. Qualified egalitarianism could support access to health care by reminding society that individuals are intrinsically equal and therefore should be given equal opportunity to have their health needs met.

Both social justice and distributive justice are important to the topic of creating a just health care system.

6. Chapter Two

Chapter Two looked at justice in the practical sense, examining the works of several scholars in the field who have applied various theories of justice to the practical problems of developing a just or more just health care system. Although there appears to be consensus among scholars that reform is necessary, there is little if any agreement on why this is so. Thus, is consensus that reform is needed sufficient to justify reform or is it necessary to look further to find additional arguments to bolster and support the moral right to health care? Since none of the theories of distributive justice is sufficient to guide the development of a just or more just American health care system, it may be necessary to develop a plural foundation — a composite theory of distributive justice —

¹¹⁷ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Fifth Edition (Oxford, UK and New York, NY: Oxford University Press, 2001), p. 234.

¹¹⁸ Norman Daniels argues for fair equality of opportunity in regard to a just health care system. See Daniels, *Just Health*; Norman Daniels, *Just Health Care* (Cambridge, UK and New York, NY: Cambridge University Press, 2001).

to guide and inform the work of developing a just or more just American health care system.

Charles Dougherty, for example, argues for a moral right to health care as a derivative of the right to be rescued. As another example, Larry Churchill argues for a moral right to health care as a corollary to enlightened self-interest. At this point it is appropriate to examine these arguments.

B. Charles Dougherty

Charles Dougherty¹¹⁹ argues for a moral right to health care derived from the “general and virtually self-evident moral intuition that there is an obligation to aid those in need.”¹²⁰ In developing his argument, Dougherty states that, although in American common law there is no duty to aid a person in need, nevertheless there appears to be consensus that a person in need, for example a child drowning in a swimming pool, has a valid moral claim for lifesaving assistance.¹²¹ By parity of reasoning, “the same child, dying of pneumonia, has a right to an injection of penicillin”¹²² and also a right to preventive care to avoid pneumonia. If society recognizes a moral right of those in need to be given assistance and a moral obligation to render such assistance, then health care can be considered a special form of need and providing access to health care would then be the means of honoring that obligation to help those in need of assistance. Thus, the

¹¹⁹ See Dougherty, *American Health Care*, Chapter 7.

¹²⁰ Dougherty, *American Health Care*, p. 119.

¹²¹ The drowning child may also claim the right to the assistance needed to avoid falling into a pool where s/he might drown. These claims — to be rescued when drowning and to avoid the danger of drowning — are analogous to claiming a right to curative and preventive health care.

¹²² Dougherty, *American Health Care*, p. 117.

“claim to a right to basic forms of health care has the same moral standing as the claim to a right to be rescued.”¹²³

1. Moral Duty To Render Aid

Dougherty then asks whether there is, in fact, a moral duty to render aid to those in need and argues that it is not necessary to prove that there is a moral duty to render aid because this duty is so basic a premise that it is virtually self-evident. “A general moral imperative to aid those in need is not a conclusion to be reached by moral reasoning but is a presumption it must start from — a practical existential presumption.”¹²⁴ Thus, if the obligation to help those in need does not require special moral justification, then the task of justifying a derivative claim for the obligation to provide health care becomes simpler.¹²⁵

Since the case for a right to health care requires persuasive argument but does not demand proof it is permissible to invoke multiple theories of justice to build the case. The basis of a right to health care is not theoretical but is instead a “morally obvious practical intuition about the duty to aid those in need and [therefore] a pluralistic approach is possible.”¹²⁶ Thus, the case for a right to health care as a derivative of the right to be rescued when in need can be built on several theories of distributive justice:

¹²³ Dougherty, *American Health Care*, p. 117.

¹²⁴ Dougherty, *American Health Care*, pp. 118-9.

¹²⁵ Justifying a moral right to health care on its own requires proof beyond a reasonable doubt, analogous to the proof required in a criminal trial. However, justifying a moral right to health care as a derivative of a general and virtually self-evident intuition regarding the obligation to aid those in need requires only a reasonably persuasive case, analogous to the preponderance of evidence required in a civil trial.

¹²⁶ Dougherty, *American Health Care*, p. 120.

utilitarianism, egalitarianism, libertarianism, and contractarianism.¹²⁷ These theories provide means of articulating the intuition that there are obligations to aid those in need.

2. Plural Foundations

“No one of [these theories] contains the complete account of the demands of justice, but each illuminates key features of this inherently complex human notion.”¹²⁸

Each of these theories is well-established, respected, and influential and each has specific strengths and weaknesses. Thus, plural foundations for a moral right to health care allow for including the strengths of each and avoiding the weaknesses.

Dougherty draws four arguments from the four theories of justice to provide plural foundations for a moral right to health care. First, Dougherty invokes utilitarian theory and argues that a right to health care could increase the chance of living a long life and thereby maximize utility. Second, Dougherty looks to egalitarianism and argues that guarantee of access to health care would express respect for the intrinsic and equal worth of persons. Third, from a perspective of libertarianism Dougherty argues that recognizing a right to health care is just compensation for social debts accumulated in the acquisition and transfer of wealth, especially health care resources. Fourth, Dougherty uses contract theory and argues that establishing a right to health care is morally incumbent upon us as part of a reasonable social contract.

In order to ensure that the least-well-off do not fall below a decent minimum condition, Dougherty expands the principles developed by John Rawls in his theory of

¹²⁷ Contractarianism is John Rawls’s theory of justice as fairness. It is also known as qualified egalitarianism.

¹²⁸ Dougherty, *American Health Care*, p. 120.

justice as fairness by inserting a principle ordered after the liberty principle but before the equality of opportunity and difference principles. This principle would assert a right of access to a decent minimum share of the necessities of life. Dougherty then uses the four principles of the modified contract, with strong influence from the other three theories, as a framework for articulating a pluralistic right to health care. The right to health care, so articulated, consists of four specific rights, ordered according to the four principles of the modified social contract.

3. Modified Social Contract: Right To Health Care

The principle of greatest equal liberty becomes the basis for a negative right of noninterference compatible with libertarianism and procedural egalitarianism. The principle of minimum security becomes the basis of a universal right of access to a decent minimum amount of health care, including basic primary and preventive care, emergency care, and other kinds of care considered to be minimally necessary and affordable. This is a broadly egalitarian principle that would also likely be insisted upon by hypothetical contractors. The principle of fair equality of opportunity grounds a right to health care interventions designed to sustain and restore normal functioning. This principle is one that contractors would agree to and it is also compatible with a utilitarian calculus. The difference principle governs general distribution of remaining wealth, allowing those with more disposable income to purchase additional forms of health care.

Dougherty argues for a moral right to health care derived from the self-evident intuition that there is a duty to aid those in need. In developing his argument, he establishes plural foundations for this moral right to health care, integrating principles

from four well-known and influential theories of distributive justice. Thus, Dougherty develops a unique and cogent argument in support of a moral right to health care.

C. Larry Churchill

In *Self-Interest and Universal Health Care*,¹²⁹ Larry Churchill argues in favor of the judicious use of multiple theories of distributive justice in formulating health care policy and developing a health care system. He confines his argument to the major modern theories (egalitarianism,¹³⁰ utilitarianism, and libertarianism) and argues that each has something to contribute to the understanding of the requirements of a just health care system.

1. Egalitarian Theories

Egalitarian theories emphasize the intrinsic worth of persons, the equalities and similarities among persons. In regard to justice in health care, egalitarian theories “focus on the need for services as the basic criterion”¹³¹ for allocating resources. Egalitarianism supports a right to health care, either a right of equal access to all that is available or a more modest right to a decent or basic minimum. However, a weakness of an egalitarian approach to health care is the difficulty of defining a health care need and determining who should be allowed to define that need. There is no way to balance the needs of the many — the society or the community — against the needs of the individual.

¹²⁹ See Larry R. Churchill, *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone* (Cambridge, MA: Harvard University Press, 1994), Chapter 2.

¹³⁰ Qualified egalitarianism is virtually identical with John Rawls’s theory of justice as fairness, a theory that is also known as contractarianism.

¹³¹ Churchill, *Self-Interest*, p. 35.

2. Utilitarian Theories

Utilitarian theories of distributive justice judge policies according to their empirical results. Right policies and actions are those that achieve the greatest good for the greatest number. Utilitarian health care policies would “weigh the benefits and burdens of various policies of allocation”¹³² and make decisions based on the results. Thus, a utilitarian approach has great strength because its emphasis on empirical reality allows for accessible and public judgments. It also encourages impartiality because, although each person’s happiness counts, no one’s happiness counts more than others. However, utilitarianism also has liabilities. Standards of justice are measured in reference to outcomes, but it is difficult to predict outcomes correctly. Another major liability is the possibility of tolerating great suffering for a few so long as the vast majority benefit.

3. Libertarian Theories

Unlike egalitarianism and utilitarianism, both of which present alternative conceptions of the common good, a libertarian theory of justice questions the existence of common or social goods. Libertarians value maximum individual liberty and the right of noninterference. The only recognized rights are negative rights. So-called positive rights are not rights but claims that require violating the rights of others in order to be satisfied. Thus libertarians believe “there is no right to health care services, since providing those services would involve coercing taxpayers to fund them and physicians to perform

¹³² Churchill, *Self-Interest*, p. 36.

them.”¹³³ Inequities in health and access to health care are unfortunate but not unfair. It is regrettable that some may suffer and die because of lack of access to health care, but it is not unjust. The poor and uninsured may obtain health care through the charity of others but there is no duty incumbent on anyone to contribute to charity.¹³⁴

The current American health care system is basically libertarian. Health care services are distributed based on purchasing power and health insurance. Thus, the libertarian approach protects economic freedom and promotes respect for personal freedom. However, libertarianism has significant weaknesses. It does not recognize commonalities among people and the degree of shared circumstances in contemporary society. In focusing on physicians’ knowledge and skills as private property for sale, libertarianism “ignores the large contributions from public funds that train physicians, support hospitals, and subsidize payments for patient services.”¹³⁵

4. Plural Foundations For A Right To Health Care

However, each of these theories has something to contribute to developing a just health care policy and therefore the best approach to health care should be pluralistic, using the “salient aspects of each theory to clarify our sense of what kind of health care system we want and can live with.”¹³⁶

Egalitarian theories inform us that security concerns are universal and that each person’s health security is equivalent to every other person’s health security. Therefore,

¹³³ Churchill, *Self-Interest*, p. 38.

¹³⁴ Allen Buchanan argues for enforced beneficence. See Allan E. Buchanan, "The Right to a Decent Minimum of Health Care," *Philosophy and Public Affairs* 13, no. 1 (Winter 1984): 55-78.

¹³⁵ Churchill, *Self-Interest*, p. 40.

¹³⁶ Churchill, *Self-Interest*, p. 41.

a right to health care must be universal in scope. However, for all their strengths, egalitarian theories do not tell us how to restrict and prioritize health care entitlements so that society can satisfy them.

At this point, utilitarianism is helpful. It can aid in determining what health care services should be offered beyond a decent minimum. All therapies would be weighted in the interest of the overall good. “Utilitarian approaches undergird solidarity by giving allocation decisions a moral reference point.”¹³⁷

However, a just health care system must not neglect the needs of the individual in favor of the public good. “Any feasible health care system must strike a balance between impartial fairness in the service of the public good and personal recognition in the service of private goods”¹³⁸

Libertarian theories, while difficult to reconcile with the goals of defining a just health care system, still have something to offer. Libertarian theories remind us that liberty interests cannot be ignored and must be considered along with concerns about security and solidarity. Libertarian theories can also help to keep the positive content of a right to health care within clear limits and be an important source of fiscal prudence in the financing of the health care system.

Thus, to varying degrees, each of the major contemporary theories of distributive justice has something to offer to the task of building a just or more just American health care system. Health care policy built on plural foundations will be stronger for drawing from multiple theories of justice.

¹³⁷ Churchill, *Self-Interest*, p. 41.

¹³⁸ Churchill, *Self-Interest*, p. 42.

V. Conclusion

Chapter Two moved beyond justice in theory and examined works of several scholars in the field, Wikler, Daniels, Powers and Faden, and Loewy and Loewy, who addressed some of the problems associated with applying theories of justice to the practical problems of health care.

Although all of the arguments are thoughtful and cogent, the approach argued by Daniels appears to be the most practical. He asks some of the questions that must be asked and answered in working toward health care reform and provides insight on how to answer the questions. Daniels proposes a method of procedural justice that could aid in the process of determining what should be included in a health care system when it is not possible to include all available services. He recommends a methodology, the Benchmarks of Fairness, as a means of evaluating and monitoring any proposed or implemented health care system. Daniels also speaks in terms that the American people, who will have to develop the political will to act and bear much of the burden for the cost of a reformed health care system, can understand and accept. Fair equality of opportunity tied to the terms of fair cooperation justifiable within society is an acceptable rationale and a meaningful justification for action.

Thus, there is a foundation for calling for reform of the American health care system. Although the problem of health care reform remains to be solved in the United States, it is not an insurmountable problem. Virtually every other developed nation has solved the problem and implemented an affordable health care system that guarantees universal access for the population.

Although it is not easy to apply a theoretical understanding of justice to the practical problems of health and access to health care and arrive at or even work toward developing a just or more just health care policy, the problem is not insoluble and can be resolved if sufficient political will exists. Virtually every other developed industrialized nation has implemented a health care system that guarantees universal access. The United States alone fails to guarantee access to health care for its entire people. If other nations can resolve the problem of how to grant access to health care for all, then surely the United States can also resolve the problem and create a just health care system.

Creating such a just health care system will have to be accomplished through the political and legislative processes because, in contemporary American society a moral right, such as the moral right to health care supported in Part One of this dissertation, must be transformed into a legal right in order to be recognized and honored. Part Two of this dissertation will examine health care policy, including some of the efforts to transform the moral right to health care to a legal right to health care for all Americans. Chapter Three will focus on what other nations have done in regard to guaranteeing universal access to health care and Chapter Four will focus on what Americans have as yet failed to do in regard to guaranteeing universal access to health care for all Americans.

Part Two: Policy

Chapter Three:

What Others Have Done

Chapter Four:

What We (Americans) Have Failed To Do

Chapter Three

What Others Have Done

I. Introduction

Part Two of this dissertation will focus on Policy, the high-level framework or plan of action that embraces the general goals and guides the decisions and actions of an organization or institution such as the government, with particular regard to health care policy. Policy is an important step on the road to health care reform because it will ultimately provide the foundation that will transform the moral right to health care, as supported by Part One of this dissertation, into a recognized legal right.

The general thesis of this dissertation is that a social reform movement is in order and might be necessary in order to effect comprehensive reform of the American health care system because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have not succeeded.

Chapter Three will develop the thesis by first presenting a general introduction to policy and an overview of different types or categories of health care systems as these systems have been and are continuing to be developed in other nations and then examining the health care systems of four representative nations: Germany, Great Britain, Canada, and France. Chapter Three will argue that the health care systems of these paradigm nations, as has been the case in many if not all of the other nations that have developed universal access health care systems, developed on the basis of health

care systems that already existed. This could be of significant relevance and also a valuable lesson for American reformers, that reform is more likely to succeed through evolutionary, not revolutionary, change.

Part One, Justice, examined the concept of justice as Americans understand it and supported the belief that a moral right to health care, grounded in the American understanding of justice,¹³⁹ exists. Therefore reform is necessary because the contemporary American health care system does not recognize or honor that moral right to health care. Having established that reform is necessary to redress the injustice of a rights violation, Part Two will now focus on the issue of why a social reform movement is in order and might be necessary in order to effect comprehensive reform.

In contemporary American society a moral right must be transformed into a legal right in order to be recognized.¹⁴⁰ One way of transforming a moral right into a legal right, and thereby accomplishing social reform, is through the political and legislative processes, creating the policy and enacting the necessary legislation to effect reform. Virtually every other developed nation has done this. Yet in the United States, despite nearly a century of effort, health care reform has not been accomplished through the political and legislative process.

¹³⁹ This understanding of justice that supports a moral right to health care can be grounded in the Golden Rule or Ethic of Reciprocity, the terms of fair cooperation justifiable within a society that extends liberty and fair equality of opportunity to all, a derivative of the moral obligation to render aid to those in need, or as a corollary to enlightened self-interest.

¹⁴⁰ History has shown that even a legal right is not necessarily a guarantee that the right will be respected. For example, the Southern states deliberately and systematically ignored the Fourteenth (equal protection) and Fifteenth (suffrage for Negro men) Amendments to the United States Constitution for nearly a century before the Civil Rights Movement compelled the federal government to enforce the law. The existence of the legal rights, however, provided a foundation for the Civil Rights Movement.

Among its democratic, industrialized peers, the United States is the only nation that does not provide universal health care. Thus, the United States lags behind virtually every other nation in regard to social policy because it has failed to enact the comprehensive health care reform that would guarantee access to health care for the entire population. Part Two of this dissertation will examine this failure to construct policy and enact necessary legislation and focus on at least some of the reasons that health care reform has repeatedly failed, in contrast to the nearly universal success of other nations in adding health care to their complement of social services.

The focus of Part Two of this dissertation will be how policy affects the process of transforming the moral right to health care which justice demands into a legal right to health care that will enable Americans to exercise that right. Legal support for the moral right is necessary because, in American individualistic secular society, lack of legal support means lack of security in exercising that moral right. In contemporary American society, legal support is instrumentally necessary in exercising the moral right to health care.

A. Scope of Part Two

Part Two of this dissertation will be presented in two chapters. Chapter Three will present a general introduction to policy and an overview of different types or categories of health care systems as these systems have been and are continuing to be developed on an international level. This will be followed by an introduction to and discussion of the health care systems of four representative nations: Germany, Great Britain, Canada, and France.

Chapter Four will focus on what the United States has failed to do in regard to enacting legal protection for the moral right to health care supported in Part One of this dissertation. In spite of nearly a century of effort, the United States still does not guarantee Americans universal access to comprehensive health care although other social welfare legislation has been enacted and has become part of the fabric of American society. Thus, Chapter Four will examine America's social welfare policy, both successes and failures, to determine whether and how the repeated failures of health care reform might be overcome. The focus will be pragmatic achievability, presenting practical suggestions to create a workable solution to what has heretofore been an insoluble problem.

II. A Review of Terminology

Before introducing discussion of what other nations have done in regard to providing universal access to health care, it is appropriate to review some of the terminology that will be used in the discussion. Specific terms include, but are not limited to, policy, health care policy, health care system, and health care reform. Different types or categories of health care systems will be presented in order to introduce what others have done and to suggest alternatives Americans might consider when moving toward enacting health care reform legislation in the future.

A. Policy: Overview

Policy is the high-level framework or plan of action that embraces the general goals and guides the decisions and actions of organizations or institutions. Public policy, a specific category of policy, is the framework that guides the actions of government, establishing the agenda for proposing, enacting, and enforcing legislation. Social policy,

a subset of public policy, provides the framework of a broad policy of social welfare legislation, whereby organized society, usually in the form of government, acts to protect the most vulnerable, promote opportunity, and enhance the general welfare. Social policy provides a broad range of social services including but not limited to unemployment insurance, workers' compensation, old age and retirement pensions, and survivor's benefits. The need for social welfare legislation arose at the time of the Industrial Revolution with its accompanying urbanization and the consequent insecurities inherent in wage labor. Health care policy is a part of social policy and refers to the body of laws, rules, regulations, procedures, practices, and expectations that affect the nation's health care system. The function of health care policy is to provide a coherent structure that reflects a commitment to employ common resources toward achieving common goals.¹⁴¹ A coherent health care policy¹⁴² is important in order to be able to use resources efficiently and to measure progress toward achieving common objectives and goals. Current American health care policy is fragmented and contradictory but a coherent health care policy could structure the fragmentation, correct the contradictions, and provide a roadmap for future changes.

B. Health Care System

A health care system in general is a complex system, consisting of a set of interrelated and interdependent parts, designed to achieve a set of goals. Major

¹⁴¹ For a more complete discussion of policy, public policy, social policy, and health care policy, see *Politics of Social Policy in U.S.*, edited by Margaret Weir, Ann Shola Orloff and Theda Skocpol (Princeton, NJ: Princeton University Press, 1988).

¹⁴² Although Congress has enacted laws and appropriated funds to secure access to health care at reasonable cost, administrative practices have failed to establish effective regulatory control over the providers of health care who largely determine the price of services. Thus, there is a persistent and growing demand for health care reform.

components of a health care system are resources, programs, economic support, and management. Resources include personnel and facilities. Examples of programs are public health, preventive services, and education. Economic support is the financing of health care through, for example, general taxes or private insurance. Management includes a variety of functions such as planning, administration, regulation, and legislation. The endpoint of any health care system is the delivery of health care services such as primary or hospital care.

A more simplified understanding of a health care system is to view it as two separate but interrelated parts, that is, the financing of health care and the delivery of health care. This more simplified understanding of a health care system will be employed in this dissertation.

C. Health Care Reform

To reform is to amend or improve by change of form or removal of faults, abuses, and errors. Health care reform, as used in this dissertation, refers to the changes that must be made to the contemporary American health care system in order to redress the injustice of the system as it has developed and is currently structured. This would mean making the necessary changes in order to ensure that all Americans have equitable access to a health care system that provides comprehensive coverage to all.¹⁴³

In the United States, the demand for health care reform comes from several directions, including the buyers of health care, the providers of health care, and the

¹⁴³ Equitable access would mean that modern, clean, well-equipped, well-staffed health centers, medical facilities, and hospitals are available in the inner cities and the rural, sparsely-populated areas, as well as in the affluent suburban areas and city centers and that these health centers, medical facilities, and hospitals would provide comprehensive health care to all at no or minimum cost at point of service.

people who use, or would use if they had access to, the health care system. Each group demanding reform has different goals and objectives. The buyers, in the form of government, employers, big business, and insurers, want to control costs, and therefore want to know what they are getting for their money. This has threatened the “autonomy of physicians and hospitals because the answers require detailed data, close scrutiny, and outside judgment.”¹⁴⁴ In the absence of reform that would control costs, buyers protect their own self-interests by shifting costs to the population through high deductibles, co-payments, requirements that employees pay substantial portions of monthly premiums, and by refusing to insure high-risk individuals. The providers of health care demand reforms that would maximize the prestige of non-profit institutions and at the same time guarantee the autonomy of health care professionals while protecting fee-for-service payment. Thus their objective is to achieve a monopoly position.¹⁴⁵

The American people who use or would use health care services also call for reform for a variety of reasons, primarily related to access to and cost of health care. Millions of Americans lack regular access to health care because they have no health insurance, possibly because they are unemployed but more likely because, although they are employed, their employer does not provide health insurance as a benefit. Millions more have inadequate health insurance. Those who live in rural communities may lack access to health care because there is no clinic, hospital, or medical center in the area.

¹⁴⁴ Donald W. Light, "The Restructuring of the American Health Care System," in *Health Politics and Policy 2nd Edition*, ed. Theodor J. Litman and Leonard S. Robins, Delmar Series in Health Services Administration (Albany, NY: Delmar Publishers Inc., 1991), 53-65.

¹⁴⁵ Theodor J. Litman and Leonard S. Robins, *Health Politics and Policy, 3rd Edition*, Delmar Series in Health Services Administration, ed. Stephen J. Williams (Albany, NY: Delmar Publishers Inc., 1997), Chapter 10.

Inner city dwellers may also suffer from lack of adequate facilities and trained personnel. For many Americans, the cost of health care is simply too high, whether in out-of-pocket expenditures, lost time and inconvenience in traveling to a health care facility, or loss of health or life because of inadequate health care. The problems of high and increasingly escalating costs and inadequate access to competent health care produce a level of insecurity that is allied with and analogous to the insecurity faced by wage laborers in the first decades of the Industrial Revolution. The insecurity associated with industrialization and related urbanization was ultimately addressed with a broad spectrum of social welfare legislation. The insecurity of unaffordable and/or unavailable access to health care deserves no less.

The American people, using a variety of words and expressions to explain their fear and frustration, not always articulate, rarely eloquent, possibly not well-educated or aware of history or politics, probably misinformed or uninformed about what other nations have achieved in regard to providing access to health care want universal access to health care and are ready for national health insurance or at least ready to engage in the meaningful dialogue that will lead to national health insurance. They may not know how this could or would be done. They may not, and probably do not, agree on how this should be achieved but they agree on the necessity of reform.¹⁴⁶ One means of achieving a national health insurance system might be through a single-payer system funded by the government by means of taxes, but this is not the only way to achieve the goal of national

¹⁴⁶ This is an example of the locus of certitude or overlapping consensus discussed in Part One of this dissertation. See also Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley and Los Angeles, CA: University of California Press, 1988), pp. 14 and 16-19 and Wikler 1983.

health insurance. Another means of achieving reform might be to build on the existing health care system but to introduce and enforce regulations to control costs, such as global budgets and negotiated fees for health care services including physicians' fees, hospital costs, and pharmaceuticals, and to remove impediments such as denial of health insurance because of preexisting conditions.

A national health insurance system would mean reforming the way in which health care is financed in the United States and it is in this sense that health care reform will be used in this dissertation. Other changes might and probably will be necessary, such as changing the method of staffing medical centers in remote and/or sparsely populated areas, but this type of change would be a means of achieving the primary goal and not a goal in itself. Furthermore many other changes, beyond merely changing the way in which health care is financed in the United States, are desirable and necessary. However, in the interests of pragmatic achievability,¹⁴⁷ that is, in a practical approach that could lead to something actually getting done, discussion of health care reform will be limited to reform of the method of financing health care in the United States.

III. Types of Health Care Systems

Every nation has some type of a national health care system, just as it has a system of justice. Among the approximately two hundred nations, no two health care systems are exactly alike and within any one nation the health care system is continually

¹⁴⁷ In my previous career as a computer systems engineer, we would sometimes analyze a complex system that had grown haphazardly over a number of years and evaluate it as something that was so broken it could not be fixed. We would recommend that the system be held together with 'bubble gum and baling wire' while a completely new system be developed as a replacement. It is possible that a similar evaluation could be made of the American health care system. However, it is exceedingly unlikely, perhaps not even possible, to replace the current system with something brand new. Thus, in the interest of pragmatic achievability, the author of this dissertation considers reform to be reform of the method of financing health care in the United States.

changing and evolving. Nevertheless, in spite of this diversity, broad categories of health care systems can be identified, influenced by the same forces that affect a nation's social structure, particularly economic and political factors.¹⁴⁸ A nation's economic development has a pervasive impact on the development of its national health system. An impoverished nation facing rampant infectious diseases of children and malnutrition will develop a health care system significantly different than that of an affluent nation concerned with chronic diseases of the elderly. The level of economic development also influences the quantity and quality of health resources¹⁴⁹ that will be available for the health care system. Economic status will also influence the share of the nation's total resources that will be devoted to health.

A nation's political policies are of equal or even greater importance in shaping its health care system. The exercise of political power is crucial, impacting the quantity and delivery patterns of health services. Politics, however, does not exist in a vacuum, for it is influenced by history and thus today's decisions and health care systems are shaped by past events such as revolutions, colonialism, depression, and war. In the United States, for example, the protection of health, including the licensure of doctors and the operation of public health programs, is a responsibility of the states because, in the aftermath of the American Revolution, the framers of the Constitution were opposed to centralized power.

¹⁴⁸ For a more complete understanding of the many and varied factors that help determine the type of health care system a nation may develop, see Milton I. Roemer, *National Health Systems of the World: Volume One - the Countries* (New York, NY: Oxford University Press, 1991), Chapter 4; Marie L. Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World: Characteristics, Issues, Reforms* (Upper Saddle River, NJ: Prentice Hall, 1997), Chapters 1-2.

¹⁴⁹ Health resources include personnel, facilities, commodities such as drugs, medical supplies, and equipment, and knowledge, from initial training to the continual dissemination of new information and techniques.

The Industrial Revolution led to the organization of workers, and the birth of political labor parties in the late nineteenth and early twentieth centuries gave rise to social insurance programs, including provisions for medical care. In the aftermath of the Russian Revolution in 1917, the communist regime established a system of socialized health care, the first of its kind, directed by the Central Committee and Politburo of the Communist Party.¹⁵⁰ In England the renowned Dawson Report¹⁵¹ called for all health services to be delivered through a network of government health centers, an indication of how political events were changing the design of capitalist health care systems. The worldwide depression in the 1930s compelled governments throughout the world to take action to alleviate the suffering of citizens, by creating or increasing social security programs. In many countries, health insurance programs were introduced as part of these social security programs. The devastation of World War II led to significant changes in health care systems in the post-war years. Health care as part of a social insurance program has become politically popular in most countries of the world. Even the most conservative governments hesitate to make drastic changes to the system, once it has been enacted.

Major political events thus have a significant impact on the development of health care systems. Great political upheaval, such as that, for example, associated with a war, tends to mobilize society. People develop or reawaken a sense of national purpose and become motivated to do something to resolve national problems. “The energies required

¹⁵⁰ See Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, pp. 271-72; Roemer, *NHS - Volume One*, p. 87.

¹⁵¹ The Dawson Report, issued in 1920, had a pervasive influence on health care systems far beyond Great Britain. Today’s common practices of using primary care facilities as the entry point to the health care system and general practitioners acting as gatekeepers to specialists derive from the Dawson Report.

for social action may lie dormant in a country until a national crisis awakens them [and strengthens] political will for other purposes.”¹⁵² In the aftermath of crisis, people have the political will to initiate many types of change, including that associated with health care systems.

In the past century and a quarter, political forces have worked to change the relationship between government and health care systems, and government has begun to intervene in the health care market. This government intervention has acted to make health care services available to people who need them. Thus health care in many nations has been, and continues to be, gradually converted from market commodity to public good.

A. Government Intervention in the Health Care Market

Considering these two important dimensions, economic and political, it is possible to categorize any nation’s health care system according to the degree of government intervention.¹⁵³

In examining government intervention in health care, it should be remembered that there are two aspects of health care systems in which government might choose to intervene: the *financing* of health care and the *delivery* of health care. Thus, government intervention may range from little or no intervention in health care, to intervention in the

¹⁵² Roemer, *NHS - Volume One*, p. 88.

¹⁵³ There are, of course, other ways to categorize health care systems. In this dissertation, however, health care systems will be categorized by degree of government intervention.

financing of health care, to intervention in both financing and delivery of health care, to a complete government takeover of the health care system.¹⁵⁴

The first option, minimal or no government intervention in either the financing or the delivery of health care, is an entrepreneurial system. This minimal government intervention is called entrepreneurial because health care is considered to be a business or a market commodity.

The second option, government intervention in the financing of health care, is a welfare-oriented system. This second level of government intervention is called welfare-oriented because it is related to other forms of government-funded welfare-oriented programs such as pensions or disability.

The third option, government intervention in both the financing and the delivery of health care, is a comprehensive system. This third level of government intervention is called comprehensive because government assumes comprehensive responsibility for both financing and delivery of health care.

The fourth option, where the government takes over the health care system, is a socialist system. This maximum level of government intervention is called socialist because of its relationship to socialist political regimes.

Further, beyond its use as a descriptor for the third level of government intervention into health care, the literature on health care systems uses the term comprehensive in other contexts. However, in the interest of clarity, this dissertation will use comprehensive to refer to health care systems in which the government intervenes in

¹⁵⁴ Government has not intervened in the delivery of health care without also intervening in the financing of health care.

both the financing and delivery of health care and extensive in other contexts. That is, extensive will refer to the level of population coverage and/or to the level of health care services provided. For example, when a health care system is established, it most likely will begin by extending access to health care to a designated subset of the population and gradually extend access to guarantee access to the entire population. Thus, as more of the population receives access to health care, the system becomes more extensive in terms of population covered. This can also be true in regard to the types of health care services provided. A health care system may offer only preventive services such as vaccinations initially but then expand to include additional services. As expanded services are added, the health care system becomes more extensive in terms of health care services provided to the population.

Thus, the degree of government intervention ranges from minimum, as in an entrepreneurial health care system, to maximum, as in a socialistic health care system. The United States is an example of an entrepreneurial system. Cuba and many of the currently Communist nations are examples of socialistic systems.

1. Entrepreneurial

An entrepreneurial health care system, sometimes called a market-based or market-driven health care system, is characterized by a strong private market and minimal government intervention. Cost of health care for individuals and families is typically high. Private medical practice is strong and most hospital beds are in private facilities. Government programs are weak, changeable, and address only a fraction of the population. Planning may exist in theory but is ineffective in fact and there is minimal

regulation. The population has no guaranteed access to health care.¹⁵⁵ Among the affluent and industrialized nations, only the United States has an entrepreneurial health care system.

2. Welfare-Oriented

At the next level of government intervention, when the government intervenes in the financing of health care, possibly but not necessarily through taxation, is a system described as welfare-oriented. A nation with a welfare-oriented health care system places a higher priority on human welfare than on marketplace profit motivation. A welfare-oriented health care system contrasts with an entrepreneurial health care system where a higher priority is placed on the marketplace and its profit motivation than on human welfare. Germany and Canada are two of the affluent and industrialized nations that have welfare-oriented health care systems.¹⁵⁶

3. Comprehensive

At the third level of government intervention, when the government intervenes in both the financing and the delivery of health care, is a health care system described as comprehensive. In this system, market intervention has been extended to the point that virtually all the nation's population is entitled to complete health services. Limited

¹⁵⁵ In the United States, the only developed, industrialized nation with an entrepreneurial health care system, a significant number of Americans have no health insurance or have not enough health insurance to cover the cost of a serious illness. The number of uninsured and underinsured Americans continues to grow. Most Americans who do have health insurance get their coverage through their employers. Thus, in the current (2009) climate of fiscal crisis, "even families who have health insurance today are just one pink slip away from being uninsured." Edward M. Kennedy, "Quality, Affordable Health Care for All Americans," *American Journal of Public Health* 93, no. 1 (January 2003): 14.

¹⁵⁶ Belgium, France, Japan, and Australia are other affluent nations with welfare-oriented health care systems. Among the developing and transitional nations, most of the nations of Latin America, the Middle East, and Asia have welfare-oriented national health care systems.

resources may impede the full implementation of this entitlement, but existing resources are equally available to everyone. “This degree of market intervention is found only where exceptional political will has established health service as a very high priority.”¹⁵⁷ Because of this exceptional political will, funds have been allocated to build and staff health centers and hospitals that are accessible without charge to the entire population. Great Britain, an affluent industrialized nation, has a comprehensive health care system.¹⁵⁸

4. Socialist

A socialist health care system takes government intervention in the health care market to the extreme. In theory, a socialist health care system eliminates the private health care market but in practice some free market operations are retained. A socialist health care system collectivizes not only the financing of all services but also virtually all human and physical resources providing health services. Cuba is one example of a nation with a socialist health care system.

¹⁵⁷ Roemer, *NHS - Volume One*, p. 96.

¹⁵⁸ The Scandinavian countries, New Zealand, Israel, and most of the countries of Southern Europe all have comprehensive health care systems. However, even a few developing transitional nations have developed comprehensive health care systems. In these nations, government policy has explicitly declared health care to be a right for everyone, a service essentially without cost to the individual. Costa Rica is one example of a developing nation with a comprehensive health care system. Under the Constitution written in 1949, Costa Rica institutionalized social reform and explicitly banned the maintenance of an army. Expenditures that would have been made to support the military establishment were earmarked instead for education and comprehensive health care. See Roemer, *NHS - Volume One*, Chapter 12.

IV. What Others Have Done: National Health Care Systems (A Subset)

This discussion of what other nations have done in regard to health care is not, and is not intended to be, either exhaustive or complete.¹⁵⁹ Rather, the health care systems of four specific nations, Germany, Great Britain, Canada, and France will be presented. The health care systems of these nations, the systems most frequently referenced as paradigms, represent significant points in health care history. All of these health care systems provide universal access to comprehensive health care but each developed differently and each has its own unique method of financing health care.

The German health care system, the very first national system, established a baseline for all others. The British system was one of the first universal comprehensive systems to be established by a capitalistic nation. Canada developed its national health system somewhat differently than nearly every other nation and thus merits special attention. France developed national health care based on a system of private insurance.

A. Germany

Germany was the first nation to develop a program of social insurance, social security for medical care. As such, it has had a significant influence on the development of health care systems in other parts of the world. The origin of the German system of social security for health care dates back to the early nineteenth century and the great upheaval of the Industrial Revolution with the accompanying urbanization of the

¹⁵⁹ For more complete information on what other nations have done in regard to health care, see Roemer, *NHS - Volume One*; Milton I. Roemer, *National Health Systems of the World: Volume Two - the Issues* (New York, NY: Oxford University Press, 1993); Milton I. Roemer, "National Health Systems Throughout the World," *American Behavioral Scientist* 36, no. 6 (Jul-Aug 1993): 689-93; Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*; *American Journal of Public Health* 93, no. 1 (January 2003).

population. As working people moved away from the farms and settled in the growing urban centers to become wage-earning workers in factories, they lost their sense of security. Sickness, accident, or unemployment meant complete loss of earnings. To protect themselves, workers formed mutual aid societies and made regular contributions to the funds so that, if they became ill, or were injured or lost their jobs, they received compensation for lost wages and the cost of medical care. These funds were entirely voluntary, started by the people for the people.

In 1854, Prussia, one of the regions of the not-yet-unified Germany, passed a law that required all low-wage workers to be members of mutual aid societies and also required that employers make a matching contribution. Other regions established local workers' sickness funds and mutual aid societies so that, by 1871 when Otto von Bismarck became Chancellor of a newly unified Germany, there were hundreds of voluntary and some compulsory local sickness funds throughout Germany. At that time, there was also a growing working class movement, represented politically in the Social Democratic Party, a group that Bismarck considered to be a threat to the Conservative Party in control. Bismarck preempted action by the Social Democrats, action that could have nurtured the growth of socialism, by proposing legislation that became the first statutory health laws. It must be understood that health care in Germany is not a lesson about leftist politics and the power of trade unions but is rather a story of "conservative forces in society, forces [that] include public and private employers, churches, and faith-based and secular social welfare organizations."¹⁶⁰

¹⁶⁰ Christa Altenstetter, "Insights from Health Care in Germany," *American Journal of Public Health* (Washington, D.C.) 93, no. 1 (January 2003): p. 38.

Bismarck began submitting legislation in 1881. The first such bill would have established a single national sickness insurance fund for all low-wage workers, with employers and government making equal contributions. The workers, represented by the Social Democrats, opposed the bill on the grounds that it was paternalistic and little more than beggar's insurance that addressed the results of misery but did nothing to resolve the underlying causes. The ensuing debate lasted a year, but in the end both sides compromised and the Sickness Insurance Act became law in June 1883. The law required that low-wage workers be insured by one of the existing private sickness benefit societies or by new ones created for the purpose. The societies were required to "provide a minimum set of benefits, both monetary and medical, submit annual reports, and invest their funds prudently."¹⁶¹ Workers paid two-thirds of the premiums and employers one-third with corresponding administrative control. In 1884 another law provided insurance for industrial accidents. Only employers contributed to this fund because work accidents were recognized as a cost of production.

It might appear that German leaders at the time were benevolently looking out for the welfare of their people but it is more probable that the "government provided health care primarily to maintain control rather than to protect citizens in the case of illness."¹⁶² Whatever the rationale, the concept of social security dates from this period and this initial legislation and eventually spread throughout the world. Social security extended to other risks including old-age pensions, permanent disability, unemployment, death and

¹⁶¹ Roemer, *NHS - Volume One*, p. 131.

¹⁶² Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, p. 130.

survivor's benefits, maternity, and children's allowances. Most countries provide some form of social security benefits.

The 1883 law covered low-wage industrial workers but in 1889 coverage was extended to all manual workers of any income and other workers earning less than two thousand marks a year. Coverage was further extended to office and transport workers in 1903, domestic workers in 1911, all dependents of the insured between 1914 and 1918, and seamen in 1927. Coverage for pensions was added in 1941. Coverage was further extended to all employees of any income in 1970 and to farmers in 1972. At the time of the original law in 1883, there were an estimated twenty-two thousand sickness funds covering about one-sixth of the population. The number of funds was repeatedly consolidated so that by 1980 there were fewer than two thousand funds covering more than ninety percent of the population.¹⁶³ The remaining group, less than ten percent of the population, either has private insurance coverage (approximately seven percent), or has coverage provided for police officers and students or for recipients of public assistance. Germany has achieved nearly universal coverage of the German population and even extends health insurance coverage to guest workers. In addition, some people who have statutory coverage also subscribe to supplemental private insurance.

The scope of benefits has expanded from the original provision for the services of community physicians and drugs to include hospitalization, dental care, vision, and rehabilitation. Some funds also offer coverage for preventive services such as immunization or early detection of specified diseases, or other special benefits such as

¹⁶³ For additional information on Germany's universal health care system, see Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, Chapter 6; Roemer, *NHS - Volume One*, pp. 131-32; Altenstetter, "German Health Care," pp. 38-44.

home care and spa therapy. Because of the complexity of coverage, administration of the German health insurance system is complicated and fragmented. The relationships between the sickness funds and the providers of health care have been especially complex. German physicians, concerned about being dominated by the sickness funds and determined to protect their economic interests, organized a union at the turn of the twentieth century. There were numerous physician strikes but by 1920 there was a significant change in the way physicians were paid. Sickness funds were required to transmit quarterly amounts per capita based on membership to regional associations of community physicians. The physicians were then paid fees by their own medical association, rather than being paid directly by the sickness funds. Then, to stay within the quarterly allotment of funds, the medical society made any necessary adjustments of fees.

Arrangements and payments for hospital care were different because in Germany¹⁶⁴ medical care in hospitals is separate from medical care in the community. Full-time salaried physicians staff the hospitals and work entirely with in-patients.¹⁶⁵ There are no outpatient departments because ambulatory care is the responsibility and prerogative of community physicians, many of whom are qualified specialists. The sickness funds pay hospitals directly on a per diem basis; the per diem amounts are negotiated between each hospital and a federation of the sickness funds, subject to provincial approval. The hospital payments include the costs of all hospital services as well as the salaries of hospital physicians.

¹⁶⁴ The German system is actually used in most of the world outside the United States and Canada.

¹⁶⁵ The American health care system is beginning to emulate this German practice as physicians choose to practice medicine in hospitals as hospitalists rather than opting for private practice.

The German health insurance program is obviously complex, yet it provides a virtually complete range of medical and related services to almost every resident, including guest workers. Despite being defeated in two world wars, Germany has developed a more than adequate supply of health resources, including doctors, nurses, and hospitals. Although seriously disturbed, the general national health care system and the health insurance program continued to operate throughout the domination by the Nazi Party and despite the violence of World War II and the horrors of the Nazi holocaust. In the aftermath of the Second World War, health insurance continued, but with a much stronger voice for physicians and a weaker voice for workers. Only one postwar change corresponds with health policy in numerous other countries: access to specialists and hospitals was required to depend on referral from a general primary physician.

The national health insurance program has had a significant impact on the German health care system. The existence, policies, and behavior of the sickness insurance funds have had major effects on the practice of medicine and the performance of hospitals. Beyond the development of their own health care system, Germany has, as the pioneer in social insurance, greatly influenced the development of health insurance programs in other countries. In addition, “Germany has demonstrated how a mechanism for financing health services can be developed to achieve nearly one hundred percent coverage, with little disturbance to the traditional patterns of health care delivery.”¹⁶⁶ This gives Germany a special place in the world spectrum of health care systems. The entire system began with small groups of workers who acted to protect themselves by forming mutual aid societies. These societies, the backbone of the national health

¹⁶⁶ Roemer, *NHS - Volume One*, p. 135.

insurance program, became local agents of provincial and national governments.

Although physicians resisted economic domination by working-class patients, the conflict was resolved by establishing fiscal middlemen, controlled by doctors, to handle the actual payment of fees. The developing health care system retained customary principles such as free choice of doctor, private practice, and fee-for-service payment. The German system, a prime example of what can be accomplished through individual initiative and compromise, effectively demonstrates that a welfare-oriented system, that is, a system in which the government intervenes in the financing of health care, does not equate to a free ride or a handout.¹⁶⁷

The German national health system has been in effect for more than a century, expanding to include more of the population but existing essentially unchanged since its inception. The health care systems of most nations, however, either began or changed significantly in the aftermath of World War II.

B. Great Britain

Great Britain, because it was once and for many years the center of a worldwide empire, has had great cultural influence globally. As a result of this global influence, the modern British health care system has attracted worldwide attention, in part as a residual effect of empire and in part because it is significantly different than the health care systems of many if not most other developed nations. The British National Health Service (NHS), initiated in the aftermath of the Second World War, a time when many

¹⁶⁷ Although the German health care system has been branded “socialist,” it is important to note that it was started by individuals acting on their own behalf and adopted by the government to prevent the growth of socialism. And everybody pays into the system — there is no free lunch. See Altenstetter, “German Health Care.”; Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, Chapter 6.

nations were beginning to create their own health care systems, has had a significant impact on the development of health care systems throughout the world.¹⁶⁸ The structure and evolution of the British NHS have helped to elucidate the structure and functions of health care systems in general and to clarify some of the political dynamics that influence the evolution of health care systems in many places.

The British health care system is a comprehensive National Health Service (NHS), one in which the government has intervened in both the financing and the delivery of health care. However, the British NHS is neither the result of coercion by ideologists nor was it imposed by fiat, by a government committed to imposing its will on the people. Rather, the NHS is the “pragmatic outgrowth of circumstances peculiar to Britain immediately after the Second World War.”¹⁶⁹

The roots of the health care system that eventually evolved into the contemporary National Health Service can be traced to the early nineteenth century when British workers, like their counterparts in the German states, established mutual aid societies to provide sickness and medical insurance for their members. In 1911 the British government, emulating the actions of the Bismarck government in Germany, enacted the first National Health Insurance Act, providing insurance protection for low-paid workers. Although membership was not mandatory, most workers affiliated with an approved mutual aid society. Both employers and employees paid the insurance contributions and

¹⁶⁸ The British National Health Service, still considered by many to be a model health care system, is very well designed, although it has suffered somewhat because of inadequate funding. See Donald W. Light, "Universal Health Care: Lessons from the British Experience," *American Journal of Public Health* (Washington, D.C.) 93, no. 1 (January 2003): pp. 25-26.

¹⁶⁹ Atul Gawande, "Getting There From Here: How Should Obama Reform Health Care?" *The New Yorker* (New York, NY), January 26, 2009, p. 2.

the government funded the indigent and those with very low incomes. Under the original law, general practitioners were not paid directly by the societies but rather by insurance committees established by statute in each county or county borough. Physicians decided how they wished to be paid, fee-for-service or capitation.¹⁷⁰ “It is not always [or well] understood that British doctors themselves increasingly chose the straight capitation method.”¹⁷¹ By 1927 capitation was the universal and preferred method of payment because it involved less red tape and was least subject to competitive abuse.¹⁷²

The income threshold for mandatory insurance gradually increased so that by 1935 nearly forty percent of the population had coverage. However, on the eve of World War II the health insurance protection of the British population was far from complete in regard to both persons covered and benefits received.

As the nation prepared for war, British ministers realized they would have to prepare for air attacks as well as land and sea combat and that, therefore, the vulnerable civilian population would have to be protected. Millions of people were evacuated from the cities to the countryside and the needs of the evacuated population were arranged by the British government, including transport, lodging, supervision, food, and schooling for the many children whose parents had stayed behind in the cities. The Government “also had to insure that medical services were in place — both in the receiving regions, whose

¹⁷⁰ Capitation is a straight or flat fee for every person enrolled on the doctor’s membership list.

¹⁷¹ Roemer, *NHS - Volume One*, p. 192.

¹⁷² With the advent of the National Health Service in 1948, capitation became mandatory.

populations had exploded, and in the cities, where up to two million war-injured civilians and returning servicemen were anticipated.”¹⁷³

The true forerunner of the contemporary British National Health Service is the national Emergency Medical Service established by the British government as a matter of wartime necessity to supplement and ultimately to replace local services. The government built or expanded hundreds of hospitals and other medical facilities, equipped and upgraded them, and eventually operated them. “The war compelled the government to provide free hospital treatment for civilian casualties, as well as for combatants,”¹⁷⁴ and also to provide government salaries to doctors and to pay the costs of private hospitals.

The Emergency Medical Service was intended to be a temporary wartime program, but the war had destroyed the status quo and the new program was better than the old for, despite the ravages of war, the health of the population had improved.¹⁷⁵ Furthermore, British citizens did not want to return to the old health care system.

During the war, a committee was established to survey the existing national schemes of social insurance and allied services and to make recommendations on improving or replacing them. In late 1942 the committee’s report, the famous Beveridge Report, was issued, documenting the need for expansion of all branches of social insurance including pensions, unemployment, disability, and health services. The landmark Beveridge Report “recommended radical changes in the delivery of health care

¹⁷³ Gawande, "Getting There From Here," p. 3.

¹⁷⁴ Gawande, "Getting There From Here," p. 3.

¹⁷⁵ The government-provided medical and social services had lowered the infant mortality rate and improved life expectancy.

in the United Kingdom, [with] a comprehensive system [that included] access to both community-based care and hospital treatment.”¹⁷⁶ Acting on the recommendations of the Beveridge Report would have to wait until after the war.

Thus, “by 1945, when the National Health Service was proposed, it had become evident that a national system of health coverage was not only necessary, but also largely already in place — with nationally run hospitals, salaried doctors, and free care for everyone.”¹⁷⁷ The British system of universal access to comprehensive and virtually free health care “was not the product of socialist ideology or a deliberate policy process in which all the theoretical options were weighed.”¹⁷⁸ The NHS was a pragmatic approach to solving the problem of providing health care for British citizens, a conservative, practical program that built on the existing health care system, a tested system that provided adequate health care for everyone and protected the existing services that people depended upon every day. The contemporary British National Health Service, built on the foundation of the wartime Emergency Medical Service, instituted a quantum leap forward from the former, prewar limited health insurance for low-paid workers. The “entire population would be covered, the services would be comprehensive, and the financial support would not depend on insurance — hence a National Health *Service*.”¹⁷⁹ After the NHS legislation was enacted in 1946, to take effect in 1948, health care in Great

¹⁷⁶ Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, p. 221.

¹⁷⁷ Gawande, "Getting There From Here," p. 3.

¹⁷⁸ Gawande, "Getting There From Here," p. 3.

¹⁷⁹ Roemer, *NHS - Volume One*, p. 194.

Britain¹⁸⁰ became a universal social entitlement financed from public sources rather than a market commodity.

In the late 1970s a working group was appointed to examine whether the National Health Service had been successful in reducing the inequalities in health among different social classes. The study determined that, while the mortality rates of all social classes had declined, the rates of decline were substantially greater for the upper classes than for the lower classes. After thirty years of NHS benefits, “the degree of inequality between classes was actually greater than at the outset.”¹⁸¹ This did not mean, however, that the NHS had failed. Rather, it was an indication that health status depends on more than medical care. Working conditions, housing, nutrition, frequency of unemployment, level of education, family stress, and other social and environmental factors play a role as great as or greater than the role of medical care.¹⁸² The improvement in health services was not matched by similar improvements in the material conditions of life indicating that although access to health care is necessary, it is not sufficient to improve health status.

In the two preceding examples, Germany and Great Britain, as indeed in virtually all other nations that have developed national health insurance systems, the federal or national government acted to initiate the system. In the following example, provincial

¹⁸⁰ NHS resources also treated visitors to Great Britain who required medical care just as the police force protected visitors against crime.

¹⁸¹ Roemer, *NHS - Volume One*, p. 205.

¹⁸² A report issued in India at about the same time said essentially the same thing, that access to health care was but one component of all that was required to improve health status. Furthermore, the arguments of the several scholars in the field whose works were examined in Chapter Two of this dissertation (Norman Daniels; Madison Powers and Ruth Faden; Erich H. Loewy and Roberta Springer Loewy), reach similar conclusions, that, though access to health care is necessary, it is not, by itself, sufficient to improve health status.

government, in response to the will of the people, took decisive action to initiate a health care system that was subsequently adopted by the national government.

C. Canada

Although Canadian history embodies neither the legacy of the medieval guilds nor the tradition of mutual aid societies common to many European nations, Canada developed and implemented a system of national health insurance in a relatively short time. Because of this, Canada is an important example of how decisive action in a single province can create a health care system that can spread to other provinces and be adopted at the national level and how quickly change can be accomplished when the political will exists. Although statutory health insurance had been discussed in Canada at the national level for many years,¹⁸³ no action resulted. It took the decisive action of a single province, Saskatchewan, to start the ball rolling toward achieving national health insurance.

“It is no coincidence that the historical origins of the Canadian health care funding system were in the province of Saskatchewan.”¹⁸⁴ Saskatchewan, a sparsely populated western province of Canada, was one of the provinces hardest hit by the Great Depression and the concurrent years of drought. The population of Saskatchewan was made up almost entirely of small farmers and those who supported and depended on the

¹⁸³ The idea of a statutory health insurance system had been discussed since at least 1919, but no action was taken. See Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, Chapter 4; Ron Pollack, "Eleven Lessons from Canada's Health Care System," in *Looking North for Health: What We Can Learn from Canada's Health Care System*, ed. Arnold Bennett and Orvill Adams (San Francisco, CA: Jossey-Bass Inc., Publishers, 1993), pp. 159-60; Roemer, *NHS - Volume One*, pp. 162-63.

¹⁸⁴ Robert G. Evans, "Health Care in the Canadian Community," in *Looking North for Health: What We Can Learn From Canada's Health Care System*, ed. Arnold Bennett and Orvill Adams (San Francisco, CA: Jossey-Bass Inc., Publishers, 1993), p. 15.

farming industry. Residents developed a strong sense of community because their prosperity, their very livelihood, success or failure, as individuals and as a community, was determined by factors that were beyond their control, weather and world markets. People learned to rely on each other in community, to resolve community wide problems, and to assist one another through collective funding administered by the provincial government.

During the depths of the Great Depression, when the Canadian federal government did little to alleviate the suffering of the people, small groups began to form in the provinces, groups that would come together in coalition to form what would in the United States be called a third party. One such group was the Co-Operative Commonwealth Foundation (CCF), a group that called itself a social movement rather than a political party. The CCF was the first national socialist party in Canada. The intent of the CCF was to achieve fundamental social reconstruction by forming a federation of local groups to work for a socialist Canada through Parliament. The idea captured the imagination of provincial Canadians and the socialist movement took power in Saskatchewan where memories of the Great Depression were longer and more bitter than elsewhere in Canada.¹⁸⁵

Health insurance was one of the most important social reforms on the immediate postwar agenda in Canada. The federal government insisted that the regional variations in economic and social conditions were too great to impose a centralized health insurance plan and therefore the responsibility for health insurance must devolve to the provinces.

¹⁸⁵ For a more thorough explication of the CCF, see Pierre Berton, *The Great Depression: 1929-1939* (Canada: Anchor Canada, 1990), pp. 88, 159-64, and 204-10.

However, because the financial and administrative burden would be great, it might be possible either for the federal government to provide financial assistance to the provinces or for the provinces to delegate authority to the federal government. Although the federal government established working committees that recommended a national health insurance program through various forms of cost sharing, the Canadian Medical Association (CMA) opposed any form of national health insurance on principle and no legislative action was taken. However, in Saskatchewan the CCF had gained decisive control and despite the federal stalemate on health insurance, the CCF government inaugurated its own government-financed hospital insurance program. This encouraged other provinces to take action and strengthened public demand for health insurance.

The Saskatchewan Hospital Services Plan (SHSP), the first province-wide program of hospital insurance, a program that guaranteed free hospital care for much of the population, was enacted in 1946 to take effect in 1947. As a trailblazer, Saskatchewan had to solve many problems that were new to the provincial government. Hospitals had to be built, to provide beds for people where they lived. Nurses, technicians, and other personnel had to be trained to staff the hospitals. Procedures for monitoring the new system of hospital insurance had to be developed and implemented as the law went into effect. The system would have to be refined based on feedback from the monitoring scheme.

After hospital insurance took effect in 1947 rates of hospital admission rose rapidly because the payment system provided incentive to maximize hospital occupancy. Therefore, a new method of payment had to be devised, an approach that set an annual budget for hospital expenses, assuming ninety percent occupancy, and paid one-twelfth

of this amount to the hospital each month, regardless of actual patient load. Thus, there was no incentive to overcrowd. The process required careful review of hospital operating budgets and the setting of reasonable standards for personnel, supplies, food, and all other items necessary for hospitals of a given size. The Saskatchewan method worked and a similar method of global budgeting was adopted in the other provinces. Applying the process required uniform hospital accounting procedures and a competent staff of administrative consultants from all key aspects of hospital operations in addition to general hospital administrators and accountants.

Although details of the administrative procedures evolved, the basic strategies developed in Saskatchewan were adopted by British Columbia when it enacted its hospital insurance plan in 1949 and by Alberta when it enacted its plan in 1950.

In 1957, the federal government passed the Hospital Insurance and Diagnostic Services Act (HIDS) to fund fifty percent of the cost of such programs for any provincial government that adopted them. The HIDS Act outlined five conditions: public administration, comprehensiveness, universality, portability, and accessibility. These remain the pillars of Canada's health care system.

By 1961 all ten provinces, having agreed to start HIDS Act programs, had hospital insurance plans and Canada had achieved a nationwide program of hospital insurance in a short time without usurping provincial prerogatives. By confining benefits to hospitalization, Canada took a first step toward comprehensive health insurance that “was politically acceptable, offered important leverage for health service planning, was

agreeable to both hospitals and doctors, and yet met a deeply felt need in the general population.”¹⁸⁶

The next logical step was insurance for physician’s care and once again Saskatchewan acted first and decisively. In Saskatchewan, the HIDS Act meant that the federal government would pay for half of their current SHSP program. The provincial government decided to use the freed money to extend health coverage to include payment to physicians and enacted the Saskatchewan Medical Care Insurance Act in 1962. Despite provision of free choice of doctor and fee-for-service remuneration, physicians objected to direct payment by the government with a fixed, though negotiated, fee schedule and called the first strike by doctors in North American history. The strike lasted twenty-three days and was settled only after intense negotiation and concessions on both sides. The settlement retained the basic principles of universal coverage and government control but private fiscal intermediaries would handle payment and physicians could charge more than the official fees. However, the “actions of physicians in the Saskatchewan situation tarnished the image of the medical profession in the eyes of politicians and many citizens.”¹⁸⁷ Physicians were viewed as self-serving in the face of strong public sentiment for the new system. In spite of the strike the doctor’s care insurance was implemented and within two years average Saskatchewan medical incomes rose from the lowest of the ten provinces to the highest. The Saskatchewan Medical Care Insurance Act proved to be a success.

¹⁸⁶ Roemer, *NHS - Volume One*, p. 165.

¹⁸⁷ Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, p. 74.

In 1966 the federal government introduced the Medical Care Act¹⁸⁸ that extended the HIDS Act cost-sharing to allow each province to establish a universal health care plan and by 1971 all Canadian provinces were covered by hospital and medical care insurance. In 1984, the Canada Health Act, which prohibited user fees and extra billing by physicians, was passed. In 1999, the prime minister and the premiers of most of the ten Canadian provinces reaffirmed in the Social Union Framework Agreement that they are committed to health care that is comprehensive, universal, portable, accessible, and publicly administered.

Canada remains the sole example to date of decisive action that began at the grassroots level and spread outward and upward. The people of Saskatchewan through their elected representatives created a health care system that spread horizontally to other provinces and also percolated upward to the federal level. Thus, the Canadian health care system merits a special place in the history of health care reform. Further, the welfare-oriented model of the Canadian health care system demonstrates that a country can collectivize financing of nearly all health care costs, make essential services available to everyone, and leave intact the basic organizational structures that deliver health care.¹⁸⁹

D. France

The French health care system reflects a highly individualistic and free-market ideology in character with the unique combination of devotion to individual personal freedom and government under highly centralized authority that is the legacy of the

¹⁸⁸ Federal government action in 1966 also set up the Canadian Medicare system.

¹⁸⁹ See Raisa Berline Deber, "Health Care Reform: Lessons from Canada," *American Journal of Public Health* (Washington, D.C.) 93, no. 1 (January 2003): 20-24; Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, Chapter 4; Roemer, *NHS - Volume One*, pp. 161-70.

French Revolution and the subsequent period of domination by Napoleon Bonaparte. In France, as a result of the French Revolution, all public hospitals are controlled locally under laws and regulations issued by the national government.¹⁹⁰

The modern French health care system “combines universal coverage with a public-private mix of hospital and ambulatory care.”¹⁹¹ Although financing is collectivized, the delivery of health services remains essentially one of private practice with fee-for-service payment. Health insurance is compulsory and no one may opt out.

The French program of national health insurance (NHI) has its roots in the nineteenth century when industrial workers and miners formed local sickness funds and voluntary mutual-aid societies for health protection. Later the government got involved and created a relatively centralized national set of requirements. In 1928, the first national health insurance act mandated compulsory participation by lower-paid workers. In 1930, a social insurance act instituted compulsory payroll deductions as a mechanism for funding the compulsory health insurance. At that time, “only employees in lower-paid categories of major commercial establishments and manufacturing industries were included on a compulsory basis.”¹⁹² Other workers, however, could participate on a voluntary basis. After the legislation of 1928 and 1930, the French national health insurance system remained essentially unchanged until after the Second World War.

¹⁹⁰ For more detailed information on the French national health system, see Roemer, *NHS - Volume One*, pp. 150-53; Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, Chapter 7; Victor G. Rodwin, "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States," *American Journal of Public Health* (Washington, D.C.) 93, no. 1 (January 2003): pp. 31-7; Gawande, "Getting There From Here," pp. 3-4.

¹⁹¹ Rodwin, "French National Health Insurance," p. 31.

¹⁹² Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*, p. 153.

In 1945, President de Gaulle and the French government faced the problem of how to ensure that the French population had decent health care after the devastation of World War II. The situation in France, however, was significantly different than the situation in Great Britain. Because the Germans had occupied France, the French government had never initiated an Emergency Medical Service comparable to that in Great Britain so there was no significant public insurance or hospital sector. The only health insurance system in place was the system legislated in 1928 on the foundation of the sickness funds established by workers in the nineteenth century, and this system of “collective insurance funds financed through a self-imposed payroll tax...became the scaffolding for the contemporary French health care system.”¹⁹³ The French government had neither the time nor the resources to create an entirely new health care system so it took the pragmatic approach and built on what it already had and expanded the “existing payroll-tax funded, private insurance system to cover all wage earners, their families, and retirees.”¹⁹⁴

Although a limited version of national health insurance in France has existed since 1928, and a commitment to extend coverage was made in 1945, it still required more than half a century of effort to provide health insurance coverage for the entire population of France. Thus, the growth of the French system provides insight on “how to ensure universal coverage through incremental reform while maintaining a sustainable

¹⁹³ Gawande, "Getting There From Here," p. 3.

¹⁹⁴ Gawande, "Getting There From Here," p. 3.

system”¹⁹⁵ that is satisfactory to the people and limits any perception of health care rationing or restrictions on patient choice.

The French health care system combines universal coverage with a public-private mix of hospitals and ambulatory care. French physicians are generally in fee-for-service private practice. Patients pay the physician’s fees and are then reimbursed under the system of National Health Insurance (NHI). Health insurance is compulsory so all residents are automatically enrolled with an insurance fund based on their occupational status. “Health insurance funds are not permitted to compete by lowering health insurance premiums or attempting to micromanage health care.”¹⁹⁶ In addition to NHI coverage, more than ninety percent of the population subscribes to supplementary health insurance to cover benefits not provided by NHI. Under the French health care system, there are no gatekeepers controlling access to specialists or hospitals.

The French system of NHI is financed primarily by various taxes. Approximately ninety percent of NHI financing comes from employer payroll taxes, a “‘general social contribution’ levied by the French treasury on all earnings, including investment income,”¹⁹⁷ and payroll taxes on employees. Other sources of revenue to finance NHI include special taxes on automobiles, tobacco and alcohol, a specific tax on the pharmaceutical industry, and subsidies from the government. Under NHI, insurance plans operate on a traditional indemnity model so that physicians in private practice are

¹⁹⁵ Rodwin, "French National Health Insurance," p. 31.

¹⁹⁶ Rodwin, "French National Health Insurance," p. 32.

¹⁹⁷ Rodwin, "French National Health Insurance," p. 34.

paid directly by patients on the basis of a national fee schedule and the patients are then reimbursed by their local insurance funds.

Hospital reimbursement varies according to whether the hospital is proprietary or public. Proprietary hospitals are reimbursed on a negotiated per diem basis and public hospitals are paid based on an annual negotiated global budget. "Prescription drug prices are set by a commission that includes representatives from the Ministries of Health, Finance, and Industry."¹⁹⁸ Charges for services provided by health professionals are negotiated every year within the framework of national agreements worked out by representatives of the health professions, the health insurance funds, and the national government. Once negotiated, fees must be respected by all physicians.¹⁹⁹ Patients are reimbursed according to the negotiated fees.

Under the French system of NHI, health insurance coverage for severely ill patients improves. This is in stark contrast to Medicare and private insurance in the United States, where serious illness almost always means increasing out-of-pocket expenditures for patients.

France spends substantially less on health care²⁰⁰ than does the United States yet, according to most measures of health status,²⁰¹ the French are healthier than Americans.

¹⁹⁸ Rodwin, "French National Health Insurance," p. 34.

¹⁹⁹ Some specialists, particularly those located in major cities, may engage in extra billing, but NHI does not cover the extra billing. This is one reason that patients may choose to subscribe to supplementary insurance.

²⁰⁰ In 2000, France expended 9.5% of its GDP on health care compared with 13.0% of GDP expended in the United States. See Rodwin, "French National Health Insurance," pp. 31-34.

²⁰¹ See Rodwin, "French National Health Insurance," pp. 34-35 and Gawande 2009 *Getting There*: pp. 3-4.

Furthermore, the French are significantly more satisfied with their health care system than Americans are with the American system.

V. Relevance of Work of Other Nations for the United States

A. Paradigm Nations

Of all the hundreds of nations that have initiated universal coverage national health systems, four were selected to be examined in this dissertation: Germany, Great Britain, Canada, and France. The health care systems of these nations, the systems most frequently referenced as paradigms, represent significant points in health care history. It is appropriate at this time to indicate why these four specific nations were selected.

Germany was selected because it was the very first nation to institute a system of compulsory, state-subsidized, national health insurance. As such, it has acted as a baseline for all other systems of national health insurance. The German health care system is a welfare-oriented system, one in which the government has intervened in the financing, but not the delivery, of health care. The German system demonstrates how a mechanism for financing health services can be developed and slowly expanded to cover the entire population, including guest workers, with little disturbance to the traditional patterns of health care delivery.

Great Britain was selected because it is one of the first nations to implement a publicly funded comprehensive National Health Service (NHS), a system in which the government intervened in both the financing and the delivery of health care. Although British workers, like their German counterparts, had established mutual aid societies, and an early version of the contemporary NHS dates to the early twentieth century, the real foundation of the NHS that was enacted in 1946 and established in 1948 is the

Emergency Medical Service that was founded as a wartime necessity as part of the preparation for protecting and caring for the British people during World War II. Thus Britain was selected because it used a very pragmatic approach to solving peacetime issues related to health care, and built a modern system on the foundation of the emergency system that already existed.

Canada was selected because it established a national health system somewhat differently than either Germany or Great Britain. In both Germany and Britain, the impetus for instituting national health systems came from the national government, from the top down. In Canada, the impetus for a health care system began at the province level and spread, horizontally to other provinces, and vertically to the national level. Thus, Canada was selected because it is a prime example of how the impetus for reform can begin at a local level and spread outward and upward to include the entire population. The welfare-oriented model of the Canadian single-payer national health system demonstrates how first a province and eventually a nation can collectivize the financing of nearly all of its health care costs, develop and implement excellent management information systems, and make essential services available to everyone without modifying the traditional patterns for delivering health care services.

France was selected because its National Health Insurance (NHI) is based on a system of private insurance financed by taxes, primarily payroll taxes. Like the Germans and the British, French workers had established mutual aid societies and these became the backbone of the NHI law enacted in 1928, a law that covered only a very small segment of the population. The current system evolved from the early legislation and expanded very slowly. The first major effort to expand NHI coverage began in 1945 in the

aftermath of World War II. President de Gaulle and the French government, like British, used a pragmatic approach to resolving postwar health care problems. Unlike the British, the French had no significant public insurance or hospital sector in place, so the current French system is based on the only system that existed after the devastation of World War II, a private insurance system funded by payroll taxes. Thus France was selected as a paradigm nation because private insurers provide health insurance coverage and because a modern system was built on the skeleton of the existing system.

B. Relevance for the United States

The four paradigm nations (Germany, Great Britain, Canada, and France) share many characteristics with the United States. All are affluent, developed nations, with stable democratic political systems and well-established capitalistic economic systems. All the nations, including the United States, have established social welfare programs, providing social security benefits for their citizens. Yet, there is a significant difference between the social welfare programs of the paradigm nations and that of the United States: the paradigm nations provide universal health care coverage for the citizenry and the United States does not.

The health care systems of the four paradigm nations were established at different times under different political and economic circumstances, no two are exactly alike, and all have evolved over time since their inception. What, then, might be the relevance of these universal coverage health care systems for the United States? What might the United States learn from the accomplishments of the four paradigm nations?²⁰²

²⁰² The discussion of the relevance of the health care systems of the four paradigm nations is based on my own experience in working on health care reform for nearly a decade and a synthesis and analysis of material drawn from the following sources: Lawrence D. Brown, "Comparing Health Systems in Four

1. Coverage Is More Than Care

One relevant lesson is to understand that there are moral and cultural foundations to universal coverage in addition to the financing and delivery of health care services.²⁰³ Universal coverage entails core values of solidarity, community, and equity, values that are, or appear to be, lacking in the United States. Americans do have the ability to work for the good of the many in emergency situations,²⁰⁴ but do not seem to be able to do so in more normal circumstances. It is possible, however, that many, or even most, Americans embrace the core values of solidarity, community, and equity but that they are not well-organized or vocal and so are overwhelmed by the rugged individualists and libertarians who appear to be better organized and more vocal. Americans who lack health insurance or have insufficient health insurance are not organized, cohesive, or politically active and so do not make their voices heard.

2. Any Major Funding Approach Will Work

Another relevant lesson is that there is no one funding mechanism that is the ace of trumps over all other methods of financing. The four paradigm nations have different methods of financing universal health care because each has developed the method that

Countries: Lessons for the United States," *American Journal of Public Health* 93, no. 1 (January 2003): 52-56; Altenstetter, "German Health Care."; Light, "British Universal Health Care."; Deber, "Health Reform in Canada."; Rodwin, "French National Health Insurance."; Gawande, "Getting There From Here."; Atul Gawande, "The Cost Conundrum: What A Texas Town Can Teach Us About Health Care," *The New Yorker* (New York, NY), June 01, 2009, 1-11; Lassey, William R. Lassey, and Martin J. Jinks, *Health Care Systems Around the World*; Roemer, *NHS - Volume One*; Roemer, *NHS - Volume Two*.

²⁰³ The paradigm nations all provide coverage for all citizens but also have opportunity for private, supplemental insurance coverage. Unlike dire predictions, the insurance industry will not cease to be.

²⁰⁴ Consider, for example, the response of ordinary American citizens to the 9/11 attack or to natural disasters such as earthquakes, fires, and floods or to industrial accidents such as miners trapped in a collapsing mine.

works for it, culturally, economically, politically, and socially. “The good news for the United States is that any major funding approach will work.”²⁰⁵ The bad news is that no such approach seems to command consensus. The problem with financing health care in the United States is further exacerbated by the fact that proponents of reform cannot or will not present a united front in support of whatever funding strategy seems to stand some chance of being passed into law. Considering the imposing strength of the opponents of reform, supporters really need to give up their personal favorites and focus on the good of the many. Furthermore, at some point Americans will have to learn to discuss taxation as intelligent, mature, rational adults. “No other nation believes that universal coverage can be won and sustained without candid debate about taxes.”²⁰⁶ It will take political courage to discuss taxes and tax increases and a spirit of compromise among advocates of reform in order to move reform of the American health care system through the political agenda.

3. Controlling Costs

A third relevant factor is the importance of recognizing the need for controlling costs. The four paradigm nations “all expect that structured negotiations between payers and providers will hold the line on costs.”²⁰⁷ In all cases, hospitals and physicians are reimbursed according to negotiated fee schedules, insurance rates are negotiated, and prices for drugs and other pharmaceuticals are negotiated. Global budgets are in place and enforced. In the United States, however, all talk of publicly set limits on health

²⁰⁵ Brown, "Comparing Health Systems," p. 52.

²⁰⁶ Brown, "Comparing Health Systems," pp. 52-53.

²⁰⁷ Brown, "Comparing Health Systems," p. 53.

spending is rejected and equated with “rationing.” Yet, limits on health spending do exist and are enforced,²⁰⁸ but they are set and enforced by the profit-motivated health care industry, to enhance the profitability of the bottom line.

4. Legitimate Role for Government

Another relevant lesson for the United States is that a statutory framework must be in place to regulate national health insurance financing and provider reimbursement. Comprehensive rules and regulations must be drafted, adopted, and enforced to regulate the health care industry, both payers and providers. Furthermore, it is absolutely necessary to recognize that the government has a legitimate role to play in overseeing the rules, regulations, and framework of the national health care system.

5. Necessity of Taking Action

There are, of course, other relevant factors and lessons for the United States to learn, in addition to these enumerated here. But perhaps the most significant lesson for the United States is the necessity of acting to initiate a universal coverage health care system. The four paradigm nations, and many other nations as well, mustered the political will and overcame the political struggles to put universal coverage into place. Not one of the systems was perfect at its initiation and all have evolved over time. Yet, the citizenry of each nation is satisfied with their health care system, something that cannot be said about the relationship between Americans and the American health care

²⁰⁸ Patients could learn about limits to coverage by reading the extremely fine print in their insurance policies. It is more likely that they discover these limits when faced with catastrophic illness that requires very expensive forms of treatment and learn that they do not have the necessary coverage.

system. Once the universal coverage health care system is established, the citizens will not give it up and the governments would not dare to abolish it.²⁰⁹

VI. Summary

Since every nation must face the burdens of disease, disabilities, and death, and develop the resources and social action plans to respond to these burdens, every nation has some type of a national health system, just as it has systems of agriculture, industry, education, and justice.²¹⁰ Among the nearly two hundred nations, no two health care systems are exactly alike, and within any given nation the health care system is continually changing and evolving. For many years, health care was relatively simple: the physician provided the service and the patient paid the bill.

In the past century and a quarter, this simplistic model underwent numerous changes, many centered on government intervention in the health care market. The first program of social insurance, social security for health care, developed in Germany in the late nineteenth century and the idea spread throughout the world. Other nations began to develop national health systems similar to that of Germany, but incorporated differences based on their own economic development and political structure. In the aftermath of World War II, many nations began to view health care as a fundamental human right and took steps to create policy and enact legislation to recognize and honor that right for their people.

²⁰⁹ One exception to this is Australia, where universal coverage was established, repealed, and quickly reestablished. See Roemer, *NHS - Volume One*, pp. 170-76.

²¹⁰ These national health systems may be inadequate, unstructured, and informal but, nevertheless, they do exist. See Roemer, *NHS - Volume One*, Chapter 3.

There are as many unique types of health care systems as there are nations with health care systems but in general they can be categorized according to the degree of government intervention in the health care market and subcategorized according to the level of economic development and political orientation of the nation. However, subcategories according to level of economic development and political orientation are beyond the scope of this dissertation.

Thus in this dissertation, according to degree of government intervention in the health care market, four categories, from minimal to maximal government intervention, are differentiated: entrepreneurial, welfare-oriented, comprehensive, and socialistic. A strong private market, minimal government intervention, high cost, and no guaranteed access to health care for the population characterize an entrepreneurial health care system. The United States is the only developed industrialized nation with an entrepreneurial health care system.

In nations with welfare-oriented health care systems, government has intervened to collectivize the financing of health services to make them accessible to all or nearly all of the population. Patterns of health service delivery have remained essentially unchanged, that is, under private market conditions.

Nations with comprehensive health care systems have gone further than merely collectivizing the financing of health services and have modified substantially the pattern of health service delivery. In general, these systems have evolved from welfare-oriented systems, have extended coverage incrementally from one population group to another, and thus have achieved universal population entitlement to health care. These health care

systems are comprehensive because they both “provide comprehensive scopes of health services and cover the population comprehensively or universally.”²¹¹

Nations with socialist health care systems have gone beyond collectivized financing and modified patterns of health service delivery and have attempted, in theory, to eliminate the private health care market and replace it with system control and central planning. In socialist health care systems, the government directly controls all resources, human and physical, providing health services, including professional education and production of pharmaceuticals.

The health care systems of four nations, Germany, Great Britain, Canada, and France, were examined in this chapter. Germany was the first nation to introduce a national health system and it has served as a model for many other nations. Great Britain was the first developed and industrialized nation to move beyond a welfare-oriented health system to a comprehensive national health service, a system based on the Emergency Medical Service developed as a matter of necessity during World War II. Canada was the only nation to date to initiate health care reform at the grassroots level and create a system that then spread both horizontally to other provinces and vertically to the national level.²¹² France developed universal coverage on the foundation of the private insurance system that was in place after World War II.

²¹¹ Roemer, *NHS - Volume One*, p. 181.

²¹² The United States is the only developed industrialized nation that has not yet developed a health care system that guarantees access to health care for all Americans. This failure to act will be the focus of Chapter 4 of this dissertation.

Nearly every nation has mustered the political will to develop a health care system that provides care to all or nearly all residents. Nations with unique problems have been very creative in finding solutions for these specific problems.²¹³

Developing and implementing a national health system, whether welfare-oriented, comprehensive, or any other type, is not an insurmountable problem. The national health systems of the four nations presented in this chapter are a very small subset of the systems that have been developed in the past century and a quarter. Obviously, resources are needed, human and material, and management, financing, and a variety of other factors must be considered. However, it appears that the political will to act is the ace of trumps in developing a national health care system. Many nations have mustered this political will, but the United States has not, at least not yet. The next chapter of this dissertation will present what the United States has failed to do in regard to developing a policy and enacting the legislation to provide the population with comprehensive health care coverage.

²¹³ Costa Rica made a commitment to human welfare and abolished its standing army, redirecting funds that would have been allocated to the military establishment to health care and education. New Zealand created dental nurses to resolve the high incidence of dental disease that was discovered when young men were being examined for the World War I draft. Australia created bush nurses and the Flying Doctor Service. The Soviet Union trained *feldshers* as physician assistants and instituted an Emergency Medical Service. To eliminate redundancy, Norway integrated health care for the military into the Norwegian health care system. These nations cited here are but a few examples of the creativity brought to bear on solving unique and specific health care problems.

Chapter Four

What We (Americans) Have Failed To Do

I. Introduction

The general thesis of this dissertation is that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have not succeeded. Part One of the dissertation focused on Justice and argued that Americans have a moral right to health care grounded in the Golden Rule or Ethic of Reciprocity, the terms of fair cooperation justifiable in a democratic society, as a derivative of the obligation to aid those in need, or as a corollary to enlightened self-interest. Since the current American health care system does not recognize or honor this moral right to health care, reform is in order. Furthermore, this moral right must be transformed into a legal right to health care because in American secular society, lack of legal support means lack of security in exercising a moral right. In contemporary American society, legal support is instrumentally necessary in exercising the moral right to health care. A moral right is transformed into a legal right through the policy agenda and the political and legislative processes.

Thus, in keeping with the thesis of this dissertation, that a social reform movement is called for in order to effect comprehensive reform of the American health care system Part Two focuses on policy, the creation of the framework and enactment of

the legislation, to accomplish health care reform. Chapter Three presented a broad overview of various types of health care systems and examined in greater detail the health care systems of Germany, Great Britain, Canada, and France. These nations are only four of the nearly two hundred nations that have acted through the political and legislative process and established, in law at least, health care systems that provide access to care for their entire populations.²¹⁴ The United States is the only industrialized affluent nation that has not acted to make access to health care a legal right for all, despite a century of effort to create the policy and enact the legislation to create a universal access health care system. It is because the many attempts to reform the American health care system through the political and legislative process have failed that a social reform movement to accomplish that reform is called for.

Chapter Four will develop the thesis, that a social reform movement for health care is in order and might be necessary to accomplish substantive reform of the current health care system by examining America's social welfare policy, specifically five paradigms,²¹⁵ both successes and failures, to determine whether and how the repeated failures of health care reform might be overcome. The focus will be pragmatic achievability, presenting practical suggestions to create a workable solution to what has heretofore been an insoluble problem. Chapter Four will argue that the American people were actively involved in the two successful attempts to enact social welfare legislation,

²¹⁴ For a variety of reasons, not least of which is the high cost of health care, not all systems are fully implemented so that not every person has access to health care in fact. But the laws that will provide a foundation for exercising the right to health care have been enacted. Further, virtually every nation that has implemented a system of universal health care began by extending access to a limited segment of the population and then gradually extending coverage to the entire population.

²¹⁵ The 5 paradigms are: FDR and Social Security; Truman and the first attempts to enact National Health Insurance; LBJ and Medicare/Medicaid; Nixon and HMOs; and Clinton and the Health Security Act.

Social Security and Medicare, but that such activism was missing in the other attempts and that therefore the active involvement of the American people may be necessary to accomplish reform.

A. Social Policy Overview

Chapter Four will present a broad overview of the American health care system and America's social welfare policy, both successes and failures to enact legislation to establish and expand a broad range of social welfare legislation. Social policy and the concomitant social welfare legislation is that subset of public policy whereby organized society, usually in the form of government, acts to protect the most vulnerable, promote opportunity, and enhance the general welfare. Education is an example of a welfare measure directed at promoting opportunity that is not a constitutionally-guaranteed right but nevertheless has long been not only provided at taxpayer expense but also compulsory for the young.²¹⁶ Social policy provides a broad range of social services including, but not limited to, unemployment insurance, workers' compensation, disability insurance, old age and retirement pensions, and survivor's benefits. Workmen's Compensation, a welfare measure designed to protect the vulnerable worker, is the first example of social insurance in America, one that changed the common law concept of the liability of workers and employers.²¹⁷ However, social welfare legislation, designed to

²¹⁶ Education is an excellent example of all of society providing for the needs of a segment of society. Not all Americans have children, or have children that need to be educated now. Some Americans bypass the public education system in favor of private schools. Not needing or using the public education system does not relieve Americans of the burden of financing public education. However, the American education system is also in need of reform. The system needs additional funding to be able to resolve problems of overcrowded schools and classrooms. Beyond this, too many children are too hungry to be able to pay attention to learning.

²¹⁷ Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge, MA: Harvard University Press, 1970), pp. 10-13.

improve the security of the population, in the home and on the job, in youth and old age, whether sick, injured, or in robust health has been only partially enacted in the United States. One gaping hole in American social welfare policy is health care, a benefit for the population that is conspicuous by its absence.

B. Scope of Chapter Four

Chapter Four will examine the history of health care reform in the context of broader social reform, delineating the strategy and tactics that opponents have used to defeat reform and constructing a framework for further action by the American people²¹⁸ to counteract the success of the organized opposition and compel the government to act in the best interests of the people.²¹⁹ Despite the numerous attempts to effect comprehensive Health Care Reform in the past century, that component of social welfare legislation has not yet been enacted. Chapter Four will examine five examples of efforts to enact social welfare legislation, focusing on the similarities and differences among these efforts and extracting lessons that might be learned from them that could be applied to future attempts to accomplish health care reform. These five paradigm efforts occurred during the presidencies of Franklin Delano Roosevelt (FDR), Harry S. Truman, Lyndon Johnson (LBJ), Richard Nixon, and Bill Clinton. Of the five efforts, only two

²¹⁸ In the past, Americans have been supportive of, but not totally committed to, health care reform. There is a quantum difference between support and total commitment.

²¹⁹ Heretofore, the lack of active involvement by the American people has contributed to the failure of reform attempts whereas the active involvement of special interest groups, health care providers, and the health insurance industry has virtually guaranteed that health care reform would be defeated. In any future attempt to enact health care reform legislation, the American people will almost certainly have to be actively involved and participating in the process. This participation will necessarily include both voting in unprecedented numbers and also grassroots activism, analogous to that associated with other great social reform movements that have altered the course of American history.

were successful. Although all five involved social welfare legislation, only four were specifically oriented to health care reform and of these, only one was successful.

C. The American Health Care System

The American health care system is unlike any other in the industrialized world because Americans have no social safety net in regard to the cost of health care and citizens are not guaranteed access to health care as they are in virtually every other developed nation. More than forty-five million Americans,²²⁰ nearly twenty percent of the population, have no health insurance and hence no regular access to health care.²²¹ Another significant segment of the population has inadequate health insurance and hence

²²⁰ See websites for current statistics on number of uninsured Americans: National Coalition on Health Care, 2008, 12 June 2009 <<http://www.nchc.org/facts/coverage.shtml>>; , 25/June 2008, CDC, 12 June 2009 <<http://www.cdc.gov/nchs/about/major/nhis/released200806.htm>>.

²²¹ Two aspects of this statement need further commentary: First, the percentage of Americans without health insurance is rapidly approaching the percentage of Americans who were unemployed during the Great Depression, a time when more were unemployed than at any other time in American history. The crisis of having nearly a quarter of the population unemployed precipitated the social welfare legislation of the 1930s. The crisis in health care has not yet precipitated a comparable reform of the health care system. Second, in the interests of accuracy, it is necessary to point out that the uninsured do have access to hospital emergency rooms, the most expensive form of health care in the system. However, by no stretch of the imagination can a “quick fix” by an unfamiliar physician under extraordinary circumstances to resolve an emergency situation be compared to regular health care by a personal physician. The emergency room solution to the problem of the uninsured is no more than a bandage on a cancer. Furthermore, many hospitals are closing their emergency rooms, leaving the uninsured with no health care that is within their reach. It should also be emphasized that emergency room care is by far the most costly form of medical care. For a more complete analysis and discussion of the effects of uninsurance, see the series of reports issued by the Institute of Medicine Committee on the Consequences of Uninsurance: Committee on the Consequences of Uninsurance of the Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington, D.C.: The National Academies Press, 2001); Committee on the Consequences of Uninsurance of the Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: The National Academies Press, 2002); Committee on the Consequences of Uninsurance of the Institute of Medicine, *Health Insurance is a Family Matter* (Washington, D.C.: The National Academies Press, 2002); Committee on the Consequences of Uninsurance of the Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (Washington, D.C.: The National Academies Press, 2003); Committee on the Consequences of Uninsurance of the Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: The National Academies Press, 2003); Committee on the Consequences of Uninsurance of the Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (Washington, D.C.: The National Academies Press, 2004).

not enough coverage to provide security in the event of a serious illness.²²² Even well insured Americans, faced with increasingly high premiums, copayments and deductibles, and the escalating costs of health care, may not be able to assume the financial burden of serious or catastrophic illness. Health care debt has become one of the leading causes of personal bankruptcy in the United States. Even considering the fact that so many are left out of the system, Americans still spend more on health care than other developed nations, approximately fifteen percent of the gross domestic product. Why then does a health care system that costs so much provide so little to so many people?

The structure of the American health care system is part of the problem. The American health care system is a market-oriented, entrepreneurial system characterized by a strong private market and minimal government intervention, with a strong private medical practice, private hospital beds, and little if any regulation. Cost of health care for individuals and families is high. Access to health care is uncertain and entirely the responsibility of the individual. Despite frequent political rhetoric about a right to health care, there has been little political will or commitment to change.

D. The Evolution of the American Health Care System

In the United States, access to health care is rationed according to the ability to pay.²²³ Payment for health care usually comes from employer-based private insurance

²²² Information, including raw data and statistics, on the underinsured is sketchy at best. The problem is not obvious until serious illness occurs and the insurance is inadequate to cover the medical expenses. One indication of the problem is an increase in the number of bankruptcies that list the cost of health care as either primary or contributing cause. For some additional information on the underinsured, see Everybody In, Nobody Out, 12 June 2009 <http://www.everybodyinnobodyout.org/FAQ/dat_underins.htm>.

²²³ Rationing can be understood in other ways, for example, when care is denied despite ability to pay. However, in this dissertation, rationing will mean that health care is denied for any reason, including the inability to pay.

which came into prominence in the aftermath of the Second World War, when wages were frozen but benefits were not, so that health insurance became an incentive that employers used to attract employees. Health insurance benefits were also part of contracts negotiated between labor unions and management. Employers, however, were neither altruistic nor beneficent; tax codes provided exempt status to employers' contributions to health benefit plans so that this income was, and remains, untaxed.

Health care benefits, when provided by employers, extended to full-time employees, and eventually to their dependents, but not to part-time workers or retirees. At a time when unemployment was not a problem and in a market that favored full-time employment, this may have been a reasonable means of providing health care benefits. At the present time, however, unemployment is a significant and growing problem. Furthermore, the current market favors part-time and contract employees, who do not qualify for the health care coverage benefit. The self-employed and those employed by small businesses are also highly unlikely to have access to employer-provided health care benefits because of the high cost of health care insurance. Owners of small businesses, for example, say that the cost of providing health care benefits would bankrupt them and force them out of business.

While many employers continue to provide health care benefits, they are taking steps to control their costs. One such step is to reduce the benefits provided to the employees; another is to eliminate coverage for employees' dependents; a third is to require employees to contribute toward the cost of health care benefits. Another measure adopted by employers is to ally with health insurers in some type of managed care organization. Thus, the employees no longer have freedom of choice in terms of

choosing physicians; they are limited to both the managed care organizations selected by employers and the physicians employed by the managed care organizations. Further, employees may not have the option of remaining under the care of a physician with whom they have developed a comfortable relationship because, in the interest of reducing cost, employers may ally with different managed care organizations in succeeding years. Thus, the freedom of choice in selecting a physician may be more myth than reality.²²⁴ The freedom of the physician to treat only those patients whom they choose is also more illusory than substantive because allying with an insurance-based managed care organization means treating the patients the organization has chosen to insure.

Still another way that employers traditionally controlled cost was to eliminate health insurance for retirees. This loss of health care benefits was a serious problem for retirees until social welfare legislation, known as Medicare, was eventually enacted to help close the gap in coverage for them. Medicaid and various programs for children's health insurance are available to provide some measure of health care for the very poor. However, there is still a significant segment of the population, Americans who are neither elderly nor really poor but whose job status does not include and income does not permit the purchase of health insurance, who are shut out of the system. The uninsured have no health insurance security blanket and those who are currently insured through employers fear loss of their security because unemployment is rising, health benefits are eroding, and out-of-pocket expenditures for health care are escalating.

²²⁴ Freedom of choice in regard to physicians is limited to those physicians affiliated with an individual's health plan. Choice of specialist will most probably be limited to the specialist selected by the primary care physician. Choice of health plan, for those who get their health insurance through their employer, is limited to those health plans the employer chooses to offer in any given year.

A comprehensive health insurance program, providing universal access to all Americans for basic preventive and therapeutic health care, would relieve these problems of insecurity. Although this remains an ideal, it has never been achieved in reality, in spite of numerous attempts in the past century to enact legislation to provide universal health insurance as part of a broad package of social welfare legislation. Examining the history of American health care reform can provide lessons for how the next attempt could be structured. This exploration will focus on the efforts of five different presidents who proposed social welfare and health care reform legislation: Franklin Roosevelt, Harry Truman, Lyndon Johnson, Richard Nixon, and Bill Clinton.

II. American Health Care Reform: Lessons from the Past

The idea of guaranteeing access to health care for all Americans dates back to the earliest days of the twentieth century, when the movement for comprehensive social reform began to examine the American social structure. The Industrial Revolution had created an urban, cash-oriented economy, in which insecurity was the rule rather than the exception. “Illness, unemployment, old-age, and industrial accidents”²²⁵ were constant threats to the personal security of workers and their families. Many believed that society as a whole should take action to lessen the dangers and improve the security of the individual. The social reformers began to formulate plans that included government intervention to resolve some modern social problems. Health and medical care was one area that needed government action. This issue of government intervention would persist as the reform movement moved into the future. A major question was and is whether

²²⁵ Hirshfield, *Lost Reform*, p. 1.

government should be involved in social welfare programs, and if so to what extent. Associated questions were and are whether government involvement should be at the federal level, the state level, or both. Workmen's Compensation, for example, was enacted, and has remained, at the state level.²²⁶

Since there was no agreement regarding the role of government in the social welfare movement, "reformers outside of government, rather than political leaders, took the initiative in advocating health insurance."²²⁷ The American Association for Labor Legislation (AALL) advocated health insurance and their view was supported by Theodore Roosevelt, the Progressive Party candidate in 1912, who supported "social insurance, including health insurance, in the belief that no country could be strong whose people were sick and poor."²²⁸ Unfortunately for the reform movement, Roosevelt was defeated by Woodrow Wilson, and it would be twenty years before another candidate for the White House would even be willing to consider national government involvement in the management of social welfare.²²⁹ In the interim, the Committee on the Costs of Medical Care (CCMC) formed in 1927 to investigate the costs and distribution of medical care; costs were rising and medical care was disappearing from rural areas because physicians were migrating to urban centers. Members of the CCMC included

²²⁶ Unemployment Compensation is another example of a state level social welfare program. However, in this time (early 2010) of high and increasing unemployment, the federal government is enacting emergency legislation to extend unemployment benefits.

²²⁷ Hirshfield, *Lost Reform*, p. 1.

²²⁸ Paul Starr, *The Social Transformation of American Medicine* (New York, NY: Basic Books, Inc., 1982), p. 243.

²²⁹ It is an interesting side note that this candidate also bore the surname Roosevelt: Franklin Delano Roosevelt was a distant relative of Theodore Roosevelt.

physicians, public health officials, dentists, economists, hospital administrators, and others.²³⁰ The Committee, fully independent and funded entirely through private foundations, would “comprehensively study the economics of health care over the subsequent five-year period”²³¹ and issue a final report on its recommendations. The CCMC did objective research and provided detailed information on the status of medical care in America, publishing more than twenty-seven reports during its five-year existence. The American Medical Association (AMA), adamantly opposed to compulsory medical care insurance, cooperated with the CCMC and waited for its final report to provide the requisite data for formulating future plans. Members of the CCMC, however, could not agree among themselves in regard to the final report, and issued both a majority report and a minority report. The majority report proposed that medical services, both preventive and therapeutic, should be provided by organized groups of physicians and related personnel, with costs placed on a group payment basis, through insurance, taxation, or both. The minority report objected to both group practice and insurance plans unless organized medicine sponsored and controlled them. The AMA immediately objected to the majority report, accusing the reformers of inciting to

²³⁰ Membership included Dr. Alexander Lambert, personal physician to Teddy Roosevelt; Winthrop Aldrich, President of the Chase National Bank; John Frey, Secretary-Treasurer of the AFL; William T. Foster, Director of the Pollack Foundation in Economic Research; Olin West, M.D., Executive Secretary of the AMA; and 15 physicians and 2 dentists in private practice. Five physicians from Public Health were also members of the Committee as was the director of research for the Milbank Memorial Fund. Some members were selected from the insurance industry, from hospitals, from nursing, and from pharmacy sources. Other members included Harry H. Moore, C. Rufus Frorem, a CPA, and I.S. Falk, who had been a member of AALL and who would later in life draft a forerunner plan to what became Medicare. There were a total of 49 members of the CCMC. See Charles C. Smith, "The Committee on the Costs of Medical Care," Presented to the Innominat Society for the Study of Medical History, 10/April 1984, 04March2009 <<http://www.innominatesociety.com/Articles/The%20Committee%20%20On%20The%20Costs%20..>>.

²³¹ Joseph S. Ross, "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States," *The Einstein Quarterly Journal of Biology and Medicine* 19 (2002): p. 130.

revolution, while the organized medical profession urged, “an orderly evolution guided by controlled experimentation which will observe the principles that have been found through the centuries to be necessary to the sound practice of medicine.”²³² This set the stage for future relationships between the medical profession and reformers; it would have a significant negative effect on the efforts of the first President who was even willing to propose major social legislation. Franklin Delano Roosevelt (FDR) was elected to office as the CCMC reports were being published, and came into power with a cooperative Democratic administration²³³ that was willing to involve the federal government in economic and social welfare problems.

A. FDR, the New Deal, and the Great Depression

FDR took office in the middle of the most severe depression in the history of the United States. It was an era in which the need for social reform was obvious and visible in the millions of unemployed, the number of failed businesses, the economic refugees on the roads, and the breadlines. Roosevelt had “the most willing and anxious Congress in [American] history.”²³⁴ It appeared that conditions were right for passing compulsory health insurance legislation. However, the Depression had revised social reform

²³² Eugene Feingold, *Medicare: Policy and Politics* (San Francisco, CA: Chandler Publishing Company, 1966), p. 90.

²³³ FDR, members of his administration, and a majority of Congress were social liberals who were members of the Democratic Party. The use of the descriptive term “Democrat” does not mean to imply that only Democrats are social liberals, or that only Democrats are willing to be cooperative, or that only Democrats can or will enact social welfare legislation. However, in the history of social welfare legislation in the United States, Democrats have been in power when most of the significant legislation has been enacted. Therefore, the term “Democrat” will be used to present factual reality. It is not necessarily an endorsement of the Democratic Party.

²³⁴ Paul K. Conkin, *FDR and the Origins of the Welfare State* (New York, NY: Thomas Y. Crowell, Company, 1967), p. 30.

priorities. In previous times, health insurance was the highest priority, a natural follow-on to Workmen's Compensation, as it had been in other developed democracies. With millions out of work, however, unemployment insurance became the leading priority, with old-age benefits second. States had already begun to take measures to improve the security of residents; before Roosevelt took office, at least seven states had enacted old-age pension legislation and one had enacted unemployment insurance legislation. Comparable legislation had been introduced in Congress shortly after his election, but Roosevelt preferred to propose his own program. The unemployed and the aged were not the only groups who needed relief, so Roosevelt spent the first year of his presidency "providing emergency relief to all people in need [and] experimenting with various schemes for restoring the economy."²³⁵

1. Committee on Economic Security (CES)

During his second year in office, Roosevelt began to work on long-term problems. He began to develop his own agenda by first appointing a Committee on Economic Security (CES), in June of 1934. The Committee, consisting of four Cabinet members and Harry Hopkins, FDR's political advisor and federal relief administrator, was charged with studying the issue comprehensively and preparing a program to be presented to Congress in January 1935. Although Roosevelt told them that he was specifically interested in unemployment and old-age pension measures, the Committee included health insurance and medical care in its research, in spite of the fact that the prevailing sentiment was that health insurance would have to wait. Walton Hamilton and Edgar

²³⁵ Richard E. Neustadt and Ernest R. May, *Thinking in Time: The Uses of History for Decision-Makers* (New York, NY: The Free Press, 1986), p. 98.

Sydenstricker, two liberal dissenters from the CCMC majority report, were named to chair the subcommittee on medical care and direct the technical study. The medical profession reacted immediately, sending telegrams to the President, protesting even the appearance of an interest in health insurance as part of the future of economic security, and printing an editorial in the *Journal of the AMA*, accusing Roosevelt of trying to ram health insurance through Congress.

The vociferous protests stopped abruptly when the CES invited prominent members of the medical profession, including the Presidents of the AMA, the American College of Physicians, and the American College of Surgeons, to participate in an advisory committee on medical care. In the fall of 1934, the American College of Surgeons endorsed compulsory health insurance, and it seemed that at least some members of the medical profession might be convinced, if not to support, at least not to oppose, health insurance as a part of the economic security package. The silence of the medical profession was no more than a momentary truce; at a National Conference on Economic Security in November 1934, prominent physicians who had seemed to be at least neutral on the subject denounced every vestige of health insurance. The CES realized that their original assessment had been correct and that “immediate action on health care would be politically unwise.”²³⁶ In the interests of getting a basic package of social reforms, in the form of unemployment insurance and old-age pensions, through Congress expeditiously, the CES placated the AMA and left their recommendations on health care out of the report that they presented to the President in January. The AMA interpreted the Committee’s capitulation as a sign of weakness, and exploited it.

²³⁶ Starr, *Social Transformation*, p. 268.

The CES expected that Congress would act quickly on unemployment and old-age programs so that health insurance could be introduced later in the same session. Since the Democrats had swept the midterm elections in 1934, giving Roosevelt an even greater majority in Congress, this was not an unreasonable expectation. In order to facilitate an introduction of the health insurance issue after the initial legislation had been passed the CES included general principles for health insurance in the January report to President Roosevelt. These general principles included assurances “that private medical practice would continue; that the medical profession would control professional personnel and procedures; and that doctors would be free to choose their patients, the method of reimbursement, and whether to participate in insurance practice.”²³⁷ Instead of recommending a definitive plan, the Committee listed several goals of a system that could be federally subsidized and state administered; these goals included the provision of adequate medical services, budgeting for wage loss and medical cost, incentives for improving medical care, and adequate remuneration to practitioners. The AMA immediately protested against the mere fact that health care was even mentioned in the CES report to the President.

The Social Security bill that was passed by Congress in 1935 included only one mention of health care, as a subject that the Social Security board might study in the future. For Roosevelt, programs for unemployment and old-age pensions were absolutely necessary, and if including health insurance would jeopardize legislation for those programs, then health care would have to be left out of the Social Security bill.

²³⁷ Starr, *Social Transformation*, p. 268.

Roosevelt was an extremely astute politician, and therefore proposed only that level of legislation that he was certain Congress would pass.

2. AMA Opposition to Health Insurance

Though health insurance legislation was omitted from the Social Security bill, the problem did not go away. People still needed medical care but with personal income drastically curtailed because of the widespread unemployment, the poor, and to some extent even the middle class, were unwilling and unable to spend their limited resources on doctors; many, if not most, who did receive medical care put off paying their bills. Physicians thus also suffered a loss of income and asked welfare departments to pay for treatment of the poor and indigent. This also caused a backlash from the AMA. Wealthy, urban physicians who comprised the vocal minority of the AMA, but who were also members of the House of Delegates,²³⁸ expected their poorer, rural colleagues to stand fast against health insurance, and to make do on a reduced income rather than accept any government payment. The AMA was able to keep its membership in line because, in order to receive hospital privileges and patient referrals, physicians had to be members of local medical societies, which required membership in the national organization. The active minority of the AMA, who ran the governing councils and were the long-term members of the House of Delegates, did not tolerate dissent. Nevertheless, a group of liberal academic physicians known as the Committee of Physicians for the

²³⁸ The House of Delegates, the governing body of the AMA, was analogous to the U.S. House of Representatives; membership, fixed at 150, was drawn from state medical societies in proportion to their membership, and reapportioned periodically. The AMA was a confederation of state medical societies, which were, in turn, confederations of county medical societies. Physicians who wanted to belong to any level of medical society were forced to belong to all three, and to pay dues at all three levels. Membership in the county society was necessary in order to obtain hospital privileges and malpractice liability protection; state level membership controlled licensure laws. See Starr, *Social Transformation*, p. 109.

Improvement of Medicine organized the only significant dissent from AMA policies in 1937. They issued a statement, signed by more than four hundred physicians, in which they “recognized that health was a ‘direct concern of the government’ and called for the formulation of a national health policy, [including] public funds to finance medical education and medical care for the ‘medically indigent.’”²³⁹ The AMA immediately denounced the Committee. Although the Committee never split off from the AMA, it did shatter the AMA’s carefully projected image of a unanimous profession speaking with one voice. This chink in the armor of the AMA brought on a new push for health insurance within the Roosevelt administration.

3. Public Concern

While the AMA was mounting its campaign against health care reform, the public was becoming “increasingly concerned about medical care during the depression [although] to most people it remained a personal not a social problem.”²⁴⁰ A series of emergency relief programs were developed to address the most critical problems; these programs were successful in the short-term because they were of limited scope and could be quickly adjusted to meet changing needs. Typically, reformers and medical profession interpreted these relief programs differently. To the medical profession, the success of these programs in providing medical care to those in need was “an excellent political weapon against permanent government systems of health insurance and care for the needy.”²⁴¹ To the reformers, the relief programs were stopgap measures, designed to

²³⁹ Starr, *Social Transformation*, p. 274.

²⁴⁰ Hirshfield, *Lost Reform*, p. 71.

²⁴¹ Hirshfield, *Lost Reform*, p. 122.

address a specific set of problems. “The basic goal of supplying adequate medical care to all citizens continued to remain a problem [and] reformation of the structure of medical care was needed,”²⁴² or the whole system would collapse. For two years, while health care advocates worked to establish the programs created by the Social Security Act, little was done toward enacting federal health insurance legislation. When the Social Security programs were firmly established, health reformers turned again to health care reform. To place the new effort on a factual basis, they began with a “comprehensive survey of health needs of the nation and the development of a national health program to meet these needs.”²⁴³ The resulting proposals included programs for public health, maternal and infant care, blind and crippled children, hospital construction, compulsory health insurance, tax-supported medical care, and temporary disability insurance to be “administered through the state governments with an agency of the federal government supplying financial and technical aid and establishing standards of quality.”²⁴⁴ When the list of recommendations was prioritized, compulsory health insurance was relegated to a secondary position but was not eliminated from the list.

4. National Health Conference

The reformers began to mobilize public support, and organized a National Health Conference in July 1938, attended by nearly two hundred representatives of labor, farmers, business, health professions, and government. As the delegates spoke about

²⁴² Hirshfield, *Lost Reform*, p. 100.

²⁴³ Hirshfield, *Lost Reform*, p. 103.

²⁴⁴ Hirshfield, *Lost Reform*, p. 106.

their own parochial interests, the group understood that only a program of national scope could resolve the fragmentation. The chairman put the question of whether there was any disagreement about the need for a National Health Program formally before the conference; not a single delegate challenged the question. After achieving unanimity on the question of the need for a national program, specific recommendations were presented and achieved a significant amount of support. At the end of the second day of the conference, the AMA, in the person of Olin West, the secretary and general manager of the AMA, “felt obliged to counter-attack”²⁴⁵ the success of the conference. West reiterated AMA opposition to medical care reform, argued against lay or government interference in medical care, and warned that, in his opinion, a compulsory health insurance system would fall under political control. The following day, the final day of the conference, Dr. Morris Fishbein, the editor of JAMA, addressed the delegates and criticized, both overtly and implicitly, not only the National Health Program but also the people who had drawn it up. According to Fishbein, the National Health Program was a form of state medicine that was un-American. Successive speakers alternated between support and vilification of the National Health Program. C.E.A. Winslow, a respected public health official who had been actively working toward health care reform for more than twenty years, spoke last. Winslow, upset by the bitterness of the AMA attack, made a personal statement in which he

“Reminded the conference of its unanimous agreement on the need for a national health program; appealed to the finest traditions of the medical profession and asked that they be applied in the needed reorganization of medical care; pleaded for local communities to organize themselves in order to provide adequate medical care to their entire

²⁴⁵ Hirshfield, *Lost Reform*, p. 112.

populations; and requested the conference delegates to work for a compulsory health insurance law which would make such community action possible.”²⁴⁶

Roosevelt was enthusiastic about the National Health Conference and so impressed by the support of the delegates that he decided to make the National Health Program an issue in the midterm congressional elections of 1938. Then, without offering any explanation, the President decided to postpone the National Health Program to the 1940 election. Thereafter, his enthusiasm waned. Perhaps it was the loss of Congressional seats in 1938, perhaps it was the imminence of war in Europe, but, for whatever reason, Roosevelt and his administration were “willing to sacrifice [national health insurance] reform on the grounds of political expediency.”²⁴⁷

Although President Roosevelt was committed to a comprehensive program of social welfare for Americans, he believed that unemployment insurance and old-age pension benefits were of primary importance in the era of the Great Depression. With the Social Security Act of 1935, Roosevelt laid the foundation of a structure of comprehensive social programs, health care among them. However, in spite of his interest in health insurance for all Americans, Roosevelt was also a consummate politician who was not willing to risk his political capital on a program that, at the time, was neither perceived to be a necessity by the American people (the National Health Conference notwithstanding), nor approved by the organized medical profession. He left it to his successors to add health insurance to the foundation of Social Security.

²⁴⁶ Hirshfield, *Lost Reform*, p. 114.

²⁴⁷ Hirshfield, *Lost Reform*, p. 108.

B. Harry S. Truman

Harry Truman became President in April 1945, when Roosevelt died shortly after beginning his fourth term of office; Truman was thus both literal and figurative successor to FDR and the New Deal. Whereas Roosevelt focused his social policy on the most needy, the unemployed and aged, Truman was committed to the common man, the blue collar workers, small businessmen, and ethnic and racial minorities. As far as Truman was concerned, the “business of representative government was to see that everyone had a fair deal.”²⁴⁸ Roosevelt did not advocate in favor of health care during the early days of his administration, but indicated that he would finally press for health insurance once the war was over. Unlike FDR, but like Teddy Roosevelt more than thirty years before, Truman believed that “the key to a nation’s strength lay in the health of its citizens,”²⁴⁹ [who] must all be physically sound to participate in a democracy.”²⁵⁰

1. First Bid for National Health Insurance Enters the Public Record

Truman was fully committed to health insurance and in November 1945, seven months after taking office and three months after the end of the war, he became the first President to work to enact health care reform legislation when he “called upon Congress to pass a national program to assure the right to adequate medical care and protection

²⁴⁸ Alonzo I. Hamby, "The Mind and Character of Harry S. Truman," in *The Truman Presidency*, ed. Michael J. Lacey (New York, NY: Cambridge University Press, 1989), p. 36.

²⁴⁹ It is interesting to speculate whether FDR’s health had influenced his view of the necessity of health insurance. After all, with his polio and its ancillary problems, FDR was hardly physically sound, but nevertheless participated fully in democracy. Of course, it is also true that Roosevelt had sufficient wealth to procure whatever medical treatment was possible, without worrying about whether that treatment would be affordable.

²⁵⁰ Mark A. Peterson, "Institutional Change and the Health Politics of the 1990s," *American Behavioral Scientist* 36, no. 6 (Jul-Aug 1993): p. 341.

from the ‘economic fears’ of sickness.”²⁵¹ Although similar to the national health plan of 1938, Truman’s program had a different emphasis. His first recommendation called for expansion of hospitals and his second recommendation called for increased support of public health and maternal and child health services; these recommendations, though in a different order, were included in the earlier proposal. Truman’s third recommendation, federal aid to medical research and education, had not been part of the earlier plan. Most significant was the fourth recommendation. Truman proposed “a single health insurance system that would include all classes of the society, even those like professionals, agricultural workers, and domestics not covered by Social Security.”²⁵² Thus the first bid for universal access to comprehensive coverage entered the public record. Truman emphasized that this plan was not socialized medicine because doctors and hospitals were free to choose the method of payment that they preferred and doctors could expect to earn more money.

2. Opposition to National Health Insurance

The AMA responded by sending out an emergency bulletin, calling upon doctors to resist Truman’s program, one that, according to an AMA editorial, would make doctors slaves. The American people seemed sympathetic to Truman’s plan, at least initially. Yet there were divisions within public opinion. Polls indicated that Americans, although they would have preferred to have a comprehensive plan for themselves, were not prepared to adopt one for the remainder of society. Not surprisingly, support of compulsory insurance varied inversely with class; opponents were better organized than

²⁵¹ Starr, *Social Transformation*, p. 281.

²⁵² Starr, *Social Transformation*, p. 281.

proponents of reform, and had more to spend on defeating the legislation than proponents could spend to ensure its success. Even in Congress, where Truman still enjoyed a small Democratic majority, reception was mixed; in the House, the committee chairman refused to hold any hearings, and in the Senate, the Republicans boycotted the hearings on the grounds that the bill was socialistic. The first bill to propose universal access to comprehensive coverage was never reported out of committee.

In 1946, the Republicans took control of Congress and had no interest in enacting President Truman's national health insurance. Senator Taft, the Republican senator who led the boycott of the committee hearings on Truman's first bill, proposed his own form of health care legislation, based on a system of welfare medicine for the poor, administered by the states and financed by federal aid. His rationale for segregating the poor from other Americans was that they "should be subject to compulsory medicine and take it the way the State says to take it."²⁵³ This sentiment,²⁵⁴ rarely so bluntly stated, has become the subtext in all succeeding discussions of universal access to comprehensive health insurance.

3. Second Attempt to Enact National Health Insurance

President Truman did not let the Republican majority derail his idea of a Fair Deal for all Americans. In 1947, he made a second attempt to reform the American health care system. Although essentially the same as the previous bill, the newer version included several significant changes, in terms of coverage, administration, and an attempt to

²⁵³ Starr, *Social Transformation*, p. 284.

²⁵⁴ A related sentiment, traced back to Calvin and his doctrine of double predestination, is that the poor are to blame for being poor. They are — or must be — lazy, shiftless, and irresponsible. Therefore they do not deserve any special help.

remove several AMA objections. Coverage, for example, “was extended and included all civilian federal employees, recipients of old-age assistance and their dependents, plus aid to blind and dependent children.”²⁵⁵ Administration would be at the local and state level, under the National Health Insurance Board. In attempting to placate the AMA, the bill made “more explicit the guarantees of professional rights of doctors, dentists, and hospitals and [emphasized] the patient’s right to a free choice of physician.”²⁵⁶ The Republican response was that national health insurance was merely part of a larger socialist scheme; the bill was never reported out of committee. Truman tried to circumvent Congress by calling for a National Health Assembly, similar to the National Health Conference during the Roosevelt era. The Assembly met in 1948, supported Truman’s program, and submitted their recommendations to the President. Needless to say, the usual suspects were opposed to the Assembly’s recommendations.

4. Presidential Campaign of 1948: Health Care as Centerpiece

In 1948, in response to a Republican challenge, Truman made health care a centerpiece of his presidential campaign, which targeted the Republican Congress on the grounds that they opposed reform.²⁵⁷ Truman campaigned on a promise to extend the New Deal, now known as the Fair Deal, in which national health insurance was the highest priority. The American voters approved of his progressive vision for America

²⁵⁵ Norbert Goldfield, "Truman and the Medical Profession: Replay or Lesson for the Nineties," *Physician Executive* 19, no. 2 (Mar-Apr 1993): p. 5.

²⁵⁶ Goldfield, "Truman and the Medical Profession," p. 5.

²⁵⁷ The rhetoric, some of which I actually remember, focused on what the Democrats did and the Republicans did not. The Democrats did propose a plan for national medical care including hospitals, medical centers, clinics, research, and national health insurance. The Republicans — the ‘do-nothing Congress’ — did not enact it.

and elected not only Truman but also a Congress that promised to extend the New Deal.²⁵⁸ In 1949, elected in his own right, Truman came to office with a clear mandate from the people to enact national health insurance legislation and once again submitted his legislation, virtually identical to that of 1947, to Congress.

5. AMA Engages Public Relations Firm to Defeat Health Care Reform

The response of the AMA made their previous opposition to health insurance seem like child's play. They engaged Whitaker and Baxter, "a public relations firm which specialized in political campaigns."²⁵⁹ Whitaker and Baxter, the firm that had masterminded the defeat of a statewide scheme of government health insurance in California, went to work for the AMA on a campaign against the Truman proposals. The reported cost of this campaign varies from one point five million dollars to nearly five million dollars. Either figure was an unprecedented sum for that era. The AMA was so certain that Armageddon was upon them that they levied a special tax on all members to finance the defeat of health reform. The campaign emphasized grassroots publicity,²⁶⁰ using letters, pamphlets, editorials, and other media to deliver its message to the American people.

The AMA campaign never discussed the content of the Truman Administration proposals for health care reform. It ignored compromise proposals made by others in

²⁵⁸ Peterson, "Institutional Change - Health Politics - 1990s."

²⁵⁹ Feingold, *Medicare*, p. 98.

²⁶⁰ This is not unlike the "Harry and Louise" television ads sponsored by the Health Insurance Association of America during the period when President Clinton was attempting to enact health care legislation in the 1990s. The insurance industry has now supplanted the medical profession as leaders of the opposition to health care reform. In the 1990s, the "Harry and Louise" ads used actors to play the parts of "Mr. and Mrs. Average American." In 1949, Whitaker and Baxter used a Hollywood actor to deliver a message condemning Truman's health care plan as socialized medicine: Ronald Reagan.

response to the Truman plan. Rather, the AMA campaign was “a broad attack on ‘socialized medicine,’ which would result in deterioration of the high quality of American medical care.”²⁶¹ The AMA campaign not only succeeded in defeating Truman’s plan for comprehensive health care reform but also provided a paradigm for future reform attempts: ignore substance and focus on emotional rhetoric.²⁶² The first bill Truman submitted after being elected in 1948 died in committee; unwilling to be pressured into conceding defeat, he sent another special message to Congress requesting passage of comprehensive national health reform legislation. The resulting bill never made it out of committee in either the House or the Senate.

Truman was not defeated because of apathy or lack of trying. However, there “was a gross imbalance in resources — material, social, and symbolic”²⁶³ — between the proponents and opponents of reform. The proponents of health care reform were social reformers who believed that they were right and that they were working for the interests of society. The opponents of health care reform,²⁶⁴ specifically the AMA as spokesmen

²⁶¹ Feingold, *Medicare*, p. 99.

²⁶² In marketing terminology, this is known as the “smoke and mirrors” approach. The air is so dense with the smoke of emotional rhetoric that it is impossible even to find a substantive issue. The mirrors reflect only what marketing wants to reflect. All substance appears to be illusion and illusion becomes real. Magicians and illusionists call this technique “misdirection.” A logician would call it the fallacy of a red herring.

²⁶³ Starr, *Social Transformation*, p. 287.

²⁶⁴ The opponents of health care reform were not all physicians and not all physicians opposed health care reform. Thus the opposition had various reasons for their opposition such as a fear of either big government or the specter of socialized medicine. Nevertheless, the most vocal, outspoken, and organized opposition to Truman’s health care reform legislation was the AMA and they were adamantly opposed to the Truman plan. Moreover, the AMA had support from other powerful interest groups, many of them from other segments of the health industry, and they were equally opposed to health care reform. See James G. Burrow, *AMA: Voice of American Medicine* (Baltimore, MD: The John Hopkins Press, 1963), Chapters 16-17; Frank D. Campion, *The AMA and U.S. Health Policy Since 1940* (Chicago, IL: Chicago Review Press, 1984), Chapter 11; Norbert Israel Goldfield, *National Health Reform American Style: Lessons from the Past* (Tampa, FL: American College of Physician Executives, 2000), Chapter 6.

for organized medicine, were working to protect physician autonomy and fee-for-service payment and thus their own self-interests,²⁶⁵ and self definitely trumped society. The opponents of reform had so much wealth on their side that they were able to conduct the war against reform on their own terms; substance gave way to appearance and right gave way to rhetoric. Rather than engage in a real discussion of the benefits and burdens of Truman's plan, the opponents waved the red flag of socialism as part of a propaganda campaign. The American public, not understanding the proposed legislation, but fearing the perception of socialism (also poorly understood), rejected health insurance. This rejection of health insurance "stands out as an exception to the postwar pattern of rising social welfare in the United States. Only in America was growing anticommunism channeled into opposition to health insurance."²⁶⁶

Instead of the universal system that Truman envisioned as the right of the common man, American society provided insurance against medical expenses to the well organized and the well off. Those without membership in influential groups lost out. "The poor, for whom health insurance was originally conceived, were precisely the ones who did not receive its protection."²⁶⁷ The failure of comprehensive health care reform did not, of course, prevent a steady increase of government intervention in medical care

²⁶⁵ The opponents of health care reform through a national health insurance program — in this instance the AMA — advocated policies that served their own interests, such as physician autonomy and fee-for-service payment. The AMA considered a system of national health insurance to be enslavement of the medical profession. See Campion, *AMA and Health Policy*, pp. 138-75; Goldfield, *National Health Reform American Style*, Chapter 2; Burrow, *AMA*, Chapters 16-17; Morris Fishbein, *A History of the American Medical Association 1847 to 1947* (Philadelphia, PA: W.B. Saunders Company, 1947), pp. 485-86.

²⁶⁶ Starr, *Social Transformation*, pp. 288-9.

²⁶⁷ Starr, *Social Transformation*, p. 289.

but rather channeled it into areas that did not threaten the sovereignty of the medical profession. However, the defeat of the various Truman proposals marked the end of the efforts to achieve universal access to comprehensive coverage; every subsequent proposal or effort at reform has been directed to specific constituencies. The next major attempt at health care reform would be directed toward the elderly,²⁶⁸ one of the constituencies addressed by Roosevelt in the Social Security legislation.

C. Prelude to Medicare

The AFL-CIO, representing American labor, was particularly interested in government-financed health care benefits for the elderly. Although the unions had been successful throughout the 1950s in negotiating health benefits for members, these benefits applied to current workers and excluded retired workers. In 1961, however, the United Auto Workers (UAW) struck a bargain with American Motors, whereby the company agreed to pay half of the retirees' health care premiums. In 1964, the UAW negotiated fully paid health care premiums for retirees. These benefits greatly helped the retirees but at the same time forced the unions to give up wage increases for active members. The dilemma of "balancing the concerns of active workers against the needs of retirees gave the trade unions a vested interest"²⁶⁹ in government-financed health insurance for the aged.

²⁶⁸ The elderly began to mobilize in favor of reform, specifically government-sponsored health insurance, during the 1950s despite the opposition of the Eisenhower administration, but they were not successful. Later, however, when they were organized into the National Council of Senior Citizens, the elderly became a force to be reckoned with.

²⁶⁹ Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (New York, NY: Oxford University Press, 2005), p. 57.

The AFL-CIO became an informal headquarters for people who were trying to do something about health insurance for the elderly and they worked closely with supporters in Congress, especially the House Ways and Means committee, to build a good record and to get committee members to understand the substantive issues. Medical care for the aged, called Medicare, became a serious topic of conversation and news stories and polls indicated that it was a leading concern of the public, second only to inflation. John F. Kennedy was the first presidential candidate to recognize the political potential of the senior vote.

By the time of the 1960 election, the various factions in the fight for health insurance for elderly Americans had coalesced into two camps: Republicans, southern Democrats, the AMA, and the Health Insurance Association of America (HIAA)²⁷⁰ were in one camp and Kennedy, northern Democrats, the AFL-CIO, and senior citizens were in the other. After Kennedy was elected,²⁷¹ the AFL-CIO began to act, and they orchestrated the fight to obtain government-financed health care for the elderly as though it were a political campaign.

1. Senior Citizen Activism

The AFL-CIO organized speeches, editorials, and debates, always working to make their case to the public and to the legislators who would write and vote on the proposed legislation. They formed the Physicians' Committee as a forum for doctors

²⁷⁰ In 1958, 260 commercial insurance companies joined together to form the Health Insurance Association of America (HIAA) to counter the efforts of the AFL-CIO. See Quadagno, *One Nation, Uninsured*, Chapter 2.

²⁷¹ Kennedy focused more on foreign policy than on domestic policy and gave Civil Rights priority on the domestic agenda but still managed to propose health care legislation that focused on the elderly. Although he tried at least three times to get a Medicare bill enacted, the legislation was stalled when Kennedy was assassinated in November 1963.

who opposed the AMA to speak out and the National Council of Senior Citizens (NCSC) to emphasize the support of the elderly. Jack Cartenson, a former staff member of the Department of Health, Education, and Welfare (HEW), who was known as somewhat of a salesman and showman, became head of the NCSC.

Cartenson was very “effective in creating public empathy for senior citizens and drawing attention to their grassroots movement.”²⁷² He made Medicare a cause and organized petition drives and letter-writing campaigns among the NCSC clubs. Thousands of senior citizens bombarded their congressional representatives with letters explaining their need and demanding support for Medicare. NCSC members were always on the scene whenever congressional hearings were held and the senior citizens gave testimony that was very effectively organized.

In the 1940s, the AMA set the terms of the debate over Truman’s proposed national health insurance, but in the 1960s elderly Americans, organized into the National Council of Senior Citizens, set the terms of the debate over Medicare. NCSC campaign literature explained that the elderly were “a deserving group who desperately needed health insurance [because] many were in poor health, a high percentage lived in poverty, and few were adequately insured.”²⁷³ The AFL-CIO had been successful in convincing the public that a real need existed and the NCSC, and the nineteen million people over

²⁷² Quadagno, *One Nation, Uninsured*, p. 65.

²⁷³ Quadagno, *One Nation, Uninsured*, p. 67.

age 65 that they represented, had the political weight to outbalance the influence of the doctors.²⁷⁴

The NCSC sent busloads of members to the 1964 Democratic National Convention in Atlantic City. In an impressive show of solidarity, fourteen thousand senior citizens marched ten blocks down the boardwalk to the convention hotel. In the months leading up to the November election, the NCSC “worked to ensure that no Medicare supporters were defeated at the polls, zeroing in on the Ways and Means Committee to pack it with Medicare supporters.”²⁷⁵

D. LBJ and the Great Society

Lyndon Johnson became President in November 1963 in a crisis that was as stunning to its generation as the Great Depression had been more than thirty years earlier, for no American President had been assassinated for nearly a century. Johnson, like Truman, was completing the term of a dead President. He immediately moved to enact legislation to fulfill the promises of Kennedy’s New Frontier, but was not successful. This was not an auspicious beginning for a man who longed to emulate his hero, FDR, and who wanted to be “a great president in the only way he knew: by wielding the power of the federal government to change the lives of Americans for the better.”²⁷⁶

²⁷⁴ Nineteen million people over age 65 were ardent supporters of Medicare; 185,000 doctors were ardently opposed to Medicare.

²⁷⁵ Quadagno, *One Nation, Uninsured*, p. 70.

²⁷⁶ Irwin Unger, *The Best of Intentions: The Triumphs and Failures of the Great Society Under Kennedy, Johnson, and Nixon* (New York, NY: Doubleday, 1996), p. 40.

In 1964 Johnson was elected President in a landslide, taking forty-four states and more than sixty percent²⁷⁷ of the popular vote, an all-time record; the Great Society was born. In the new Congress, Democrats would outnumber Republicans by two to one, the biggest Democratic majority since 1936. Northern Democrats gained a majority without the South for the first time since the New Deal. No incumbent, Republican or Democrat, who supported Medicare lost.²⁷⁸ Johnson, with congressional majorities that few liberal presidents had ever enjoyed, claimed a mandate and “intended to put both mandate and majority to good use.”²⁷⁹ Between January and October of 1965, the administration submitted eighty-seven bills to Congress and Johnson signed eighty-four of them into law. “Two of these measures — national health insurance for retirees and the poor and the first-ever general federal-aid-to education law — were historic landmarks of the social welfare state.”²⁸⁰

1. Medicare Becomes a Priority Issue

The Johnson landslide reset the timer and made Medicare a priority issue; the King-Anderson bill, the first introduced in the Eighty-ninth congress,²⁸¹ was a modest proposal to provide hospital insurance to the elderly through Social Security. In not covering ordinary doctors’ bills or drugs, it left plenty of space for private insurance and

²⁷⁷ LBJ won 61.1 percent of the popular vote.

²⁷⁸ Elder activism acted as a catalyst for LBJ’s landslide election and the subsequent enactment of Medicare. Grassroots activism by the NCSC helped to ensure that no incumbent, Republican or Democrat, who favored Medicare lost the bid for reelection.

²⁷⁹ Unger, *The Best of Intentions*, p. 76.

²⁸⁰ Unger, *The Best of Intentions*, p. 104.

²⁸¹ Literally the first of the new Congress: H.R. 1 in the House and S. 1 in the Senate.

physicians' services. The AMA and political conservatives countered with their own proposal for Eldercare, which proposed federal and state subsidies of private insurance for the elderly poor but required means testing to establish eligibility, and covered a broader range of services than the King-Anderson bill. When debate started in the House Ways and Means Committee, the ranking Republican introduced a version of the Eldercare bill that dropped the means testing and assigned costs as one-third to the beneficiary and two-thirds to the federal government.

Wilbur Mills, a fiscal conservative from Arkansas, was the Democratic chairman of the Ways and Means Committee and he was adamantly opposed to any form of government-financed health insurance.²⁸² In the past, his opposition had proved to be an insurmountable obstacle. However, when the Republicans introduced their latest version of Eldercare, Mills realized that the Republicans had outbid liberal Democrats in providing for senior citizens. Because of the institutional power vested in the chairman of the Ways and Means Committee, Mills had great latitude in crafting the Medicare legislation and the authority to get the job done. He suggested to the committee that the Medicare proposal to provide hospital insurance for the elderly be expanded to include a voluntary program of insurance to cover physician fees. Mills further suggested that the legislation should include a third component to cover the health care expenditures of poor Americans who were not included in the Medicare proposal. When the chairman's suggestions were incorporated in a newly constructed bill, the result resembled a three-layer cake.

²⁸² Mills' first congressional campaign in Arkansas had been financed by a group of doctors and they were adamantly opposed to government-financed health insurance.

2. The Three-Layer Cake

Chairman Mills and the House Ways and Means committee added a Part B to the Medicare bill, to cover doctors' bills; pensioners would have to enroll in Part B and pay a small monthly fee. The newly-drafted legislation also proposed a "separate title for the Medicare bill to pay the medical costs of welfare recipients and the medically indigent, regardless of age, the costs to be defrayed by joint state and federal outlays from general revenues."²⁸³ This separate title became known as Medicaid.²⁸⁴ Mills used the opening provided by the AMA and the Republicans to expand the very basic measure first proposed into a broad expansive program of government-funded health care. Although the add-ons were estimated to cost the federal government an additional five hundred million dollars per year, President Johnson approved the expanded legislation.²⁸⁵ On March 24, two months after the start of the hearings in the House Ways and Means Committee, Johnson "endorsed the enlarged version of Medicare as 'a tremendous step forward for all of our senior citizens.'"²⁸⁶ On April 8, after only a single day of debate, the House passed the Health care bill by two hundred votes.

²⁸³ Unger, *The Best of Intentions*, p. 111.

²⁸⁴ Although the two programs were created by the same piece of legislation, and although their names are similar, Medicaid and Medicare are very different programs. Medicare is an entitlement program funded entirely at the federal level. It is a social insurance program, focusing primarily on the elderly, i.e., people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease. The Medicare Program provides a part A to cover hospital bills, an optional part B to cover medical insurance, and an optional part D to cover prescription drugs. Medicaid, on the other hand, is a means-tested program that is not solely funded at the federal level. Medicaid is a needs-based social welfare or social protection program rather than a social insurance program. Eligibility is determined by income and other criteria. Nevertheless, in spite of the significant differences between Medicare and Medicaid, both represent success, a step forward in America's social policy.

²⁸⁵ Johnson used all of his considerable political skill to keep the legislative ball rolling but he left the details to Congress and let Mills get the credit for creating the Medicare legislation.

²⁸⁶ Unger, *The Best of Intentions*, p. 111.

Meanwhile, Johnson was moving to head off trouble in the Senate, specifically with conservative Senator Harry Byrd of Virginia, the chairman of the Senate Finance committee. Byrd had not signed on for Medicare, and “Johnson laid a plot to trap the senator into supporting the health bill against his wishes.”²⁸⁷ Byrd was invited to the White House where he walked into the middle of a nationally televised meeting with the President and nine other influential Democrats. Johnson questioned Byrd, setting up the questions so that Byrd was forced to agree that he would arrange for prompt hearing of the bill when it was referred to the Senate Finance Committee.

The Senate began to consider the bill at the end of April; significant cost control issues were raised and several distracting amendments were considered but nothing substantive was changed. As the Senate Finance Committee completed its work and prepared to report the bill to the Senate, the AMA rallied for the last time. It inserted ads in major newspapers, proclaiming Medicare to be the beginning of socialized medicine; some state medical societies also suggested that members should “boycott the federal health care program if enacted.”²⁸⁸ However, the incoming AMA president cautioned members against employing any unethical tactics in defying Congress. President Johnson also played a role in defusing this last gasp of AMA opposition to the passage of Medicare by inviting AMA leaders to the White House and both flattering and cajoling them into working for the public interest.²⁸⁹

²⁸⁷ Unger, *The Best of Intentions*, p. 112.

²⁸⁸ Unger, *The Best of Intentions*, p. 114.

²⁸⁹ Whatever LBJ promised the AMA leaders has never been revealed. (There is a presumption, based on the subsequent actions of the AMA, that LBJ gave them permission to set their own fees.) The never-revealed agreement between LBJ and the AMA is reminiscent of the meetings and negotiations between

In early July, approximately six months after the bill was first introduced, the Senate approved Medicare by a margin of more than three to one. “To honor the man who had first placed federal health insurance on the national agenda,”²⁹⁰ Johnson flew to Independence, Missouri to sign the bill at the Truman Library. Finally, and for the first time, Americans, at least a significant portion of them, would have government-sponsored access to health care. Further, the successful enactment of Medicare and Medicaid demonstrated that the opponents of health care reform “could be defeated when confronted with a rival with equal organizational capacity and greater political skill.”²⁹¹

E. Richard M. Nixon — 1970s

Richard Nixon, the first Republican President to initiate health care reform legislation, came to office in an era of domestic unrest, shortly after Martin Luther King and Robert Kennedy were assassinated. The activism that began with Civil Rights in the south in the 1950s and expanded with the elderly in their quest for health benefits escalated with race riots and mass demonstrations against American involvement in the war in Vietnam. This activism would continue as new movements advocated the rights of women, children, students, Chicanos, native Americans, gays, tenants, prisoners, welfare clients, the disabled, and patients. Out of this activism was born the notion that “health care [is] a matter of right, not privilege.”²⁹² American law, of course, did not and

Abraham Lincoln and the legislators who were reluctant to support the Thirteenth Amendment abolishing slavery. The promises that Lincoln made have never been revealed, but he was successful in getting the Thirteenth Amendment passed by a lame duck Congress in December of 1864.

²⁹⁰ Unger, *The Best of Intentions*, p. 116.

²⁹¹ Quadagno, *One Nation, Uninsured*, p. 55.

²⁹² Starr, *Social Transformation*, p. 389.

does not recognize a general right to health care. The entitlement programs, however, had created a specific set of rights to medical care for those who could qualify and the American people were ready to extend that right to all. For, while the need for health care reform continued to grow after the enactment of Medicare, the effort to create such legislation did not keep pace with need.

1. Health Security Plan

In 1970, liberal Democrats seized the initiative in regard to health care reform. When Senator Edward M. (Ted) Kennedy became chairman of the Senate Health Subcommittee, he introduced the Health Security plan, a bill that he cosponsored with Representative Martha Griffiths of Michigan.²⁹³ “Health Security called for a comprehensive program of free medical care, replacing all public and private health plans in a single, federally operated health insurance system.”²⁹⁴ This comprehensive package, though it neither required that facilities be nationalized nor insisted that physicians work on salaries, would have set a national budget, allocating funds to regions and offering incentives for prepaid group practice, and obliged private hospitals and physicians to operate within budget constraints. Furthermore, patients would make no copayments. Although never enacted, this bill became the benchmark against which other proposals were measured.

²⁹³ The Health Security plan had been drafted as a model bill by the Committee of 100 for National Health Insurance (CNHI) in Washington, D.C. The CNHI was a top-notch team of trade unionists, social activists, college professors, physicians, and liberal politicians (including Ted Kennedy and Martha Griffiths). Walter Reuther was instrumental in putting the team together to design a health insurance program that would salvage the best features of the existing system but overcome the built-in waste and inefficiencies. See Quadagno, *One Nation, Uninsured*, pp. 110-24.

²⁹⁴ Starr, *Social Transformation*, p. 394.

Nixon was opposed to any sort of compulsory federal insurance program, but the deaths of his two brothers, and the financial burden his family had to bear from his brother Harold's long illness, had both made a lasting impression on Nixon.²⁹⁵ In February 1971, the Nixon administration, responding to both the Kennedy-Griffiths bill and the American people who were clamoring for relief from the escalating cost of health care, countered with a proposal that "combined a limited employer mandate with a subsidized health insurance program for the poor."²⁹⁶ Health maintenance organizations (HMOs) were the centerpiece of Nixon's strategy. HMOs were prepaid group practices, a cleverly repackaged version of the prepaid health plans that had been around since the 1940s. With HMOs, primary care physicians would act as gatekeepers and evaluate patients before they saw specialists for treatment. In the 1970s, they were sold as a pro-market solution, an alternative to traditional fee-for-service and centralized government financing for health care.

Although Nixon's plan was too generous for conservative Republicans and southern Democrats and not generous enough for liberal Democrats, it was submitted as

²⁹⁵ Will each of us have to suffer a personal crisis in order to understand the necessity of reforming the American health care system to provide universal access to comprehensive coverage? Nixon was open to the idea of health care reform because of his brother Harold's long illness and the deaths of his two brothers. Otis Bowen, a Midwest physician and former governor of Indiana, who persuaded Reagan to sponsor the Catastrophic Coverage amendment to Medicare, had first-hand experience with the overwhelming expense of illness because his wife had terminal bone cancer and because he saw what his elderly patients suffered. Harris Wofford, the surprise upset candidate in Pennsylvania who refocused national attention on health care reform in the late 1980s and early 1990s, was married to a woman with a "preexisting condition" and he worried every time he changed jobs. As individuals and as a nation we ought to be able to learn from the experiences of others. See Neil Rolde, *Your Money or Your Health: America's Cruel, Bureaucratic, and Horrendously Expensive Health Care System: How It Got That Way and What to Do About It* (New York, NY: Paragon House, 1992), pp. 32-7; Quadagno, *One Nation, Uninsured*, pp. 115-16, 150-4, and 184.

²⁹⁶ Flint J. Wainess, "The Ways and Means of National Health Care Reform, 1974 and Beyond," *Journal of Health Politics, Policy and Law* 24, no. 2 (April 1999): p. 312.

legislation. “For the first time since the late 1940s, a president — this time a Republican — was requesting Congress to enact a nationally mandated health care program, albeit one that relied heavily on the private sector.”²⁹⁷ The HMOs moreover marked a ‘sea change’ in American medicine, one wherein physician control would have to be shared with outside parties.

2. Twenty-two Different Health Care Bills

The AMA had supported Nixon in 1968, so it was surprising that his administration proposed a system that would increase government intervention in the health care sector. However, the proposed legislation was actually a cool political calculation, for national health insurance “would clearly be an important issue in the upcoming elections”²⁹⁸ and Nixon needed an alternative to Kennedy’s much grander plan. The HMO plan did not require expenditure of large sums of money and it did involve the private sector. By July of 1971, twenty-two different health care bills were on the table. At one end of the continuum was the AMA’s Mediscore, a plan that would enhance the private sector. At the other end of the continuum was the Kennedy-Griffiths Health Security plan to collapse all existing programs into a single government plan.

In 1972, the social activism and political unrest of the times collided with the Watergate scandal, and produced a unique period in American history. Political factions within Congress were smoothing out differences and cooperating. Trust in government was still reasonably high. The American people were strongly in favor of changing the

²⁹⁷ Philip J. Funigiello, *Chronic Politics: Health Care Security from FDR to George W. Bush* (Lawrence, KS: University Press of Kansas, 2005), p. 176.

²⁹⁸ Funigiello, *Chronic Politics*, p. 116.

status quo in the health care system. The Nixon administration was desperate to pass significant domestic social legislation and thereby remove the spotlight from Watergate. The political climate was ripe for change.

In 1973, as the Watergate scandal continued to escalate, the administration proposed a new health insurance bill, a two-part plan drafted by Caspar Weinberger, the secretary of HEW. Both parts of Weinberger's plan gave the insurance industry a central role.²⁹⁹ The first part was the Comprehensive Health Insurance Plan (CHIP) and the second part was the Assisted Health Insurance Plan (AHIP).

3. CHIP/AHIP

CHIP, a bill that would have covered the whole population, involved an employer mandate and "used private insurance companies to provide coverage for the employed."³⁰⁰ AHIP, a plan wherein states would contract with private insurance companies to cover low-income and high risk individuals, "established a separate government-run program for the [unemployed], with no differences in the minimum benefit package between the two programs."³⁰¹ Patients would pay twenty-five percent of medical bills, up to a maximum of fifteen hundred dollars per year.

Kennedy joined with Representative Mills to support a plan that would use private insurers to act as fiscal intermediaries. The Kennedy-Mills bill, like the administration bill, required a comparable copayment, with a maximum of one thousand dollars per

²⁹⁹ The administration was worried about alienating their natural friends (doctors, nurses, hospital administrators, and insurance companies) but did not want to identify publicly with organized medicine or the insurance industry. The key for the administration was to work closely with those groups in developing an overall strategy for handling Congress. See Quadagno, *One Nation, Uninsured*, p. 121.

³⁰⁰ Starr, *Social Transformation*, p. 404.

³⁰¹ Starr, *Social Transformation*, p. 404.

year. Senator Kennedy was optimistic about the chances of enacting national health insurance. He believed that a new spirit of compromise was in the air and that a bill could reach the president's desk by the fall.

4. Failure to Compromise

Yet, no legislation was enacted. Organized labor and liberal organizations supported neither CHIP/AHIP nor the Kennedy-Mills bill. They refused to compromise and insisted on the original Health Security plan. Nixon was adamant about not compromising with Kennedy. Kennedy was willing to compromise, as the Kennedy-Mills bill demonstrated, but was also looking forward to the presidential election in 1976 and therefore refused to let go of legislation with which he had long been identified. In committee, the bills were subjected to a number of amendments and at least one other rival bill, Long-Ribicoff. In the end, "the perfect [became] the enemy of the good."³⁰² Rather than compromise on something workable, Congress took the alternate path of doing nothing³⁰³ one more time. A compromise probably would not have produced ideal policy, but could have led to significant, positive change. What is needed is "a politically palatable approach that can gain widespread bipartisan support and then be expanded later."³⁰⁴

Despite the fact that Americans were more receptive to universal access to comprehensive health care coverage than at any previous time, little that was of either

³⁰² Wainess, "Ways and Means," p. 320.

³⁰³ In my previous career, I worked very closely with the career military. They have their own criteria for making decisions. The best option is to make the right decision. The next-best option is to make the wrong decision. The worst possible alternative is to make no decision at all. Yet, this is the option that is taken time and again in trying to enact health care reform legislation.

³⁰⁴ Wainess, "Ways and Means," p. 329.

real or lasting benefit in regard to health care reform was proposed or accomplished between the late 1970s and the early 1990s.³⁰⁵ One striking anomaly, however, in the history of health care reform legislation in general and the history of Medicare in particular, is the Medicare Catastrophic Coverage Act of 1988.

F. Medicare Catastrophic Coverage Act

Otis Bowen,³⁰⁶ Secretary of Health, Education, and Welfare in the Reagan administration, proposed the legislation that became the Catastrophic Coverage Act. Reagan was particularly unpopular with the elderly³⁰⁷ and catastrophic care legislation might help to improve his image with them. Reagan directed Bowen to conduct a study of the issue. While the study was in process, the Iran-Contra crisis erupted, Reagan's approval rating dropped, and aides began searching for an issue that would deflect public attention from Iran-contra.³⁰⁸

³⁰⁵ Jimmy Carter, a one-term Democratic President elected in 1976, waited three years before addressing health care, then submitted a plan that was so modest and focused on cost containment, phased-in coverage, and reliance on the private sector that it might easily have been written by the Republicans. Ronald Reagan, a two-term Republican, followed Carter and with his election, the nation moved away from any serious consideration of universal access to health care and toward single-minded concern with improving national and international economic and military predominance. George H. W. Bush, who followed Reagan, viewed himself as a "guardian president" and launched no new health policy initiatives of any consequence. The Medicare Catastrophic Coverage Act was enacted at the end of Reagan's second term and repealed shortly after Bush took office. See Funigiello, *Chronic Politics*, pp. 188-217 and Chapter 8; Quadagno, *One Nation, Uninsured*, pp. 10, 124-36, and 149-54.

³⁰⁶ Bowen was a country doctor and former governor of Indiana who, because of the lengthy terminal bone cancer of his first wife, had firsthand experience with the expenses associated with catastrophic illness. He had also witnessed the distress of his elderly patients as they faced enormous health care bills after lengthy hospital stays.

³⁰⁷ Reagan had tried to cut Social Security retirement benefits and he had introduced a prospective payment system for Medicare so that patients were released from hospitals quicker and sicker. See Quadagno, *One Nation, Uninsured*, pp. 150-55; Funigiello, *Chronic Politics*, pp. 194-98.

³⁰⁸ This is not unlike what Nixon's aides were doing a decade earlier, attempting to focus attention away from Watergate.

After the 1986-midterm elections, when the Democrats regained control of the Senate, an election outcome that was particularly damaging to Reagan's image, Bowen presented the results of his study and introduced his proposal for catastrophic coverage. Bowen's plan would "expand Medicare coverage for acute hospital stays, cap an individual's out-of-pocket costs for physician services, and include federal tax credits to encourage the elderly to purchase private long-term care insurance."³⁰⁹ In general, Republicans despised Bowen's proposal, Democrats applauded it, and the insurance companies were indifferent and made no attempt to defeat the plan because they were not interested in addressing catastrophic care coverage. Reagan, persuaded by Bowen's arguments that such legislation was needed, would support expanding Medicare on one condition: "that it be financed entirely by the elderly."³¹⁰ This method of financing was an unprecedented and significant shift in the Medicare program.

1. Modest Proposal Expands

The relatively modest proposal for catastrophic coverage expanded as it moved through Congress. The final measure included prescription drugs, mammography screening, hospice care, and caregiver support for the frail elderly. The AHA endorsed the measure as long as hospital reimbursements were not cut. The AMA endorsed the measure as long as fee-for-service remained intact. The Pharmaceutical Manufacturers Association (PMA) was fiercely opposed to the drug benefit but was not able to eliminate it from the bill although they were able to delete any references to cost control. Most senior citizens' organizations supported catastrophic coverage, at least initially. Congress

³⁰⁹ Quadagno, *One Nation, Uninsured*, p. 151.

³¹⁰ Quadagno, *One Nation, Uninsured*, p. 153.

passed the Medicare Catastrophic Coverage Act in July 1988 with “huge bipartisan majorities in both House and Senate,”³¹¹ and Reagan quickly signed it into law.

As people began to understand its implications, support for the Medicare Catastrophic Coverage Act turned into active opposition. The legislation would be a great benefit to the twenty percent or so of senior citizens who had no medigap insurance and would guarantee that all Medicare beneficiaries had prescription drug coverage, but it would “only modestly improve coverage for most older people and would significantly increase taxes for a large minority.”³¹²

2. Rekindling of Senior Citizen Activism

The same type and level of senior citizen activism that had proved so effective in the drive to enact Medicare in the 1960s went to work to get the Medicare Catastrophic Coverage Act repealed. Petition drives and other protests arose almost instantaneously and senior citizens bombarded members of Congress with letters and phone calls. The elderly took to the streets in protests and demonstrations. In October 1989, just sixteen months after enacting the program, Congress repealed the Medicare Catastrophic Coverage Act. Thereafter, efforts to reform the American health care system lay dormant for several years.

The momentum for refocusing health care reform on the national political agenda started in Pennsylvania when the governor appointed Harris Wofford to replace the late John Heinz as secretary of labor and industry. Wofford, a little-known Democrat who had never been elected to public office, decided, in the spring of 1991, to run for the

³¹¹ Quadagno, *One Nation, Uninsured*, p. 155.

³¹² Quadagno, *One Nation, Uninsured*, p. 155.

United States Senate. He was clearly an underdog until he made health care reform the centerpiece of his campaign. He “produced a television ad that said, ‘If criminals have a right to a lawyer, I think working Americans should have the right to a doctor.’”³¹³ The ad struck a responsive chord with Pennsylvania voters, Democrats in every state, and virtually all Americans. Businessmen, labor unions, physicians, insurance companies, states, and American citizens, tired of the huge and ever-escalating cost of health care, frustrated with being powerless in the face of the ineffectiveness of the government, jumped on the reform bandwagon. Democrats incorporated health care reform and jobs as the two most important issues in the 1992 presidential campaign.

G. Bill Clinton and the Health Security Act — 1990s

In the early 1990s, a new wave of inflation, coupled with enormous budget deficits and recession, refocused attention on social issues. Hardships crowded in on working Americans, middle class as well as blue collar. Middle class Americans, already concerned about the high and escalating costs of health care, began for the first time to “consider the impermanence of their jobs and wonder whether they really wanted their health coverage contingent on their employment.”³¹⁴ Job loss would mean loss of the employer benefits that provided them with guaranteed access to affordable health insurance and health services. Bill Clinton, a self-styled centrist Democrat who wanted to make a large impact on America’s social welfare policy, pledged to make universal

³¹³ Funigiello, *Chronic Politics*, p. 203.

³¹⁴ Ezra Klein, "The Lessons of '94: The Three Reasons the Clinton Administration's Health Reform Effort Failed, and How the Next Democratic President Can Get It Right," *The American Prospect* 22 January 2008, Web Only Article, 07 February 2009
<http://www.prospect.org/cs/articles?article=the_lessons_of_94>.

coverage a major public policy initiative of his first hundred days in office. He underestimated the complexity, the cost, and the political hazards of health care reform.

During the 1992 presidential campaign, Clinton promised not only “to contain health care costs and guarantee universal coverage,”³¹⁵ but also to initiate the reform within his first one hundred days as president. He faced an extraordinarily poor environment for major social policy innovation. The federal budget deficit and the economy³¹⁶ had been watchwords during the campaign and Congress was more committed to deficit reduction than to health care reform. Clinton’s mandate was at best equivocal. He received only forty-three percent of the popular vote, so his authority as president was limited. His majority in the Senate was extremely narrow. If the Republicans were to filibuster his legislative agenda, Clinton would need the support of every Democrat plus three or four Republicans to ensure its passage, a level of cohesion that he was not likely to get. FDR and LBJ, both of whom accomplished major social reform, had the voter mandate and Congressional majorities to propose bold agendas but Bill Clinton had no voter mandate and almost no Congressional majority to speak of and thus very limited authority as president. It was, at best, unwise to propose major changes in social welfare legislation in such an environment. The media did not take note of the difficult political environment and Clinton envisioned his task as overcoming the disillusionment and antigovernment sentiment that had been building for two decades and restoring the progressive political tradition of the New Deal and the Great Society.

³¹⁵ Quadagno, *One Nation, Uninsured*, p. 185.

³¹⁶ Clinton had a huge sign prominently displayed in his campaign bus, a sign that read, “It’s the economy, stupid!” The lagging economy and the enormous budget deficits accrued during the Reagan-Bush era were major obstacles to considering any program that required additional spending.

1. President's Task Force on National Health Reform

Within a week of taking office, Clinton gathered cabinet officials, presidential aides, and the First Lady behind closed White House doors to hear his plan for a health security initiative, an approach centered on managed competition within a budget. Clinton next addressed the White House press corps, describing the massive task ahead and announcing the President's Task Force on National Health Reform. First Lady Hillary Rodham Clinton³¹⁷ would chair the task force and Ira Magaziner³¹⁸ would head a group of policy experts to advise the task force.

Armed with determination but lacking tight staff work and the realistic timetable that would have come from a real grasp of how long it took to achieve fundamental change in Washington, Clinton pressed on with his intent to bring health care reform to the forefront of the nation's agenda, with NAFTA³¹⁹ and the budget deficit. In spite of the existing \$4.4 trillion deficit, Clinton decided to include health care reform in the February budget. There were certain advantages to this strategy because special rules governed the budget reconciliation process, limiting debate and amendment, requiring only a simple majority to pass legislation, and making filibuster difficult.

³¹⁷ The First Lady, a lawyer by training, was described by the President as “‘better at organizing and leading people from a complex beginning to a certain end’ than anyone else he had worked with.” Funigiello, *Chronic Politics*, p. 220. Mrs. Clinton may have been the best person to chair the task force but there was confusion between her public and private persona and many were reluctant to challenge openly her ideas and decisions, simply because she was the president's wife.

³¹⁸ Magaziner was a fiercely loyal Rhodes Scholar classmate in whom Clinton had complete confidence but he was also an outsider with no previous Washington experience. Neither the Washington establishment nor the longtime advocates of health care reform trusted him. Ultimately Magaziner proved to be a major liability and he bore the brunt of criticism for the delay in producing a timely and viable reform bill.

³¹⁹ NAFTA is the North American Free Trade Agreement.

2. Favorable Initial Response

When President Clinton delivered his first budget and State of the Union address to a joint session of Congress, the initial response was favorable but almost immediately it became obvious that he was not about to score an easy legislative victory. Senate Minority Leader Bob Dole, preparing to run for the presidency in 1996 and understanding that a victory for Clinton in health care reform would destroy his chances in the Republican primaries, indicated that the Republicans would unanimously oppose Clinton's budget. To get any Republican support on a bipartisan health care bill, it would have to be proposed as a separate piece of legislation.³²⁰ The major obstacle, however, to embedding health care reform into the budget reconciliation bill was a Democrat, Senator Robert C. Byrd of West Virginia. Byrd was the chairman of the powerful Senate Appropriations Committee, a staunch defender of Senate procedure, and absolutely opposed to adding anything to the reconciliation bill that was not directly related to deficit reduction.³²¹ Senator Byrd's veto of President Clinton's grand strategy to slip health care reform in with budget reconciliation was a harbinger of problems to come in the effort to enact legislation.

³²⁰ Dole was so opposed to anything that might lead to victory for Clinton that he actually voted against multiple compromise bills that he had helped to co-sponsor. For more on Dole's role in defeating the Clinton health care proposal, see Klein, "The Lessons of '94," p. 3; Funigiello, *Chronic Politics*, p. 221.

³²¹ See Funigiello, *Chronic Politics*; Quadagno, *One Nation, Uninsured*.

3. The Task Force

The task force was too large and unwieldy³²² to be effective at policy formulation and pushed toward ever-greater detail so that the finished proposal was overly long and complex. Furthermore, the task force worked in secret,³²³ leading to resentment on the part of key stakeholder groups,³²⁴ including insurance companies, business leaders, and provider organizations. In addition, considering the membership of the task force and committees, the proposed legislation accurately reflected the anxieties of health economists and policy specialists but completely failed to address the concerns and fears of voters.³²⁵

Financing and cost containment were high priority topics that dominated the deliberations of the task force working and advisory groups, where discussion focused on

³²² Magaziner attempted to establish control of the task force by centralizing important policy choices in the hands of a smaller group of advisers, assigning a second group of advisers who were seasoned political campaigners to develop a strategy for building public and congressional support for the proposal, and appointing a third group, composed of representatives from the Office of Management and Budget (OMB) and the Council of Economic Advisors (CEA), to analyze the plan's budgetary impact but even this was not enough to streamline the work and develop efficiency and focus.

³²³ According to Ezra Klein, the great sin of the task force was not its size or its secrecy, but its very existence. It was both politically naïve and arrogant for the White House to construct the bill and present it to Congress fully formed. In America, Congress writes legislation, not always the best but certainly the most politically viable. Paul Starr echoes Klein's comments and adds that the time spent writing a health care reform plan should have been spent negotiating it. See Klein, "The Lessons of '94," p. 2; Paul Starr, "What Happened to Health Care Reform?" *The American Prospect* no. 20 (Winter 1995): p. 22.

³²⁴ Three groups from the health care industry sued the task force, claiming that Hillary Rodham Clinton was not a government employee and therefore could not chair or even attend task force meetings. This was a shrewd political move on their part for it diverted the attention of task force members and White House from the important work at hand. It also left the public and the news media with the impression that the work of the task force was yet another Washington conspiracy. The public had been inundated with government conspiracies for more than thirty years, from the Kennedy assassination to Watergate to Iran-Contra and was predisposed to distrust anything that came out of secret meetings. See Quadagno, *One Nation, Uninsured*, p. 186; Hillary Rodham Clinton, *Living History* (New York, NY: Scribner, 2003), p. 158.

³²⁵ See Klein, "The Lessons of '94," p. 3.

what form of managed competition to recommend.³²⁶ Discussions of managed competition proceeded from certain basic assumptions, some of which were highly questionable. These basic assumptions were:

- That the crisis in American medicine was attributable to the lack of competition in the health care sector;
- That workers were not sufficiently cost conscious about health insurance because their coverage was paid for by their employers;
- That Americans were over-insured and overused health care resources, a tendency encouraged by fee-for-service providers;
- That health insurance and health care should be integrated into the same health plans; and
- That the government should discipline workers as consumers and leave the insurance industry to discipline health care providers.³²⁷

To ensure that Americans became more cost-conscious, patients would pay an increased share of the costs and health benefits would be subject to taxation. Large insurance companies would control health providers to guarantee that they practiced cautiously and prudently to ensure the highest possible cost savings.

Members of the task force were extremely hostile to suggestions that Medicare be expanded. Paul Starr, a sociologist affiliated with Princeton and a member of the health policy team that drafted the plan, characterized Medicare as a prime example of how not to structure a national health program. However, Starr and others on the task force were apparently not considering the “big picture” surrounding Medicare. For, in spite of its

³²⁶ Apparently a single-payer system was never a serious contender for this attempt at health care reform. Americans, however, were familiar with and generally approved of the existing single payer system: Medicare.

³²⁷ Funigiello, *Chronic Politics*, p. 226.

imperfections, “Medicare was the largest and most popular federal health program, favored by many congressional leaders and health policy analysts, and the only [system] whose infrastructure could credibly form the basis for a broader public system.”³²⁸

4. What Americans Wanted in Health Care Reform

The task force seemed to assume that Americans wanted a drastic reform of health care, one that would entail replacing the existing system in its entirety. For all the high-powered talent, the many studies, the meetings, and the hard work that was invested in the health care reform effort, the task force apparently did not connect with Americans who wanted to reform a familiar system so they would have greater access at a more reasonable cost.³²⁹ The lengthy and confusing health care debate made the public more afraid of change than they were of the status quo. People could not understand the many options, especially since these options were disguised by language and terminology that have little meaning to the average person. Even after two years of intense debate, most people did not understand the concepts of the various reform options, concepts such as managed competition, health alliances, or negotiated budgets, well enough to be able to make an informed choice. Thus, the people stayed with the devil they knew, the existing health care system with its escalating costs and diminishing access, rather than opt for health care reform.³³⁰

³²⁸ Funigiello, *Chronic Politics*, p. 231.

³²⁹ Americans will walk forward slowly, even onto a ledge, if they are sure they can scramble back to the safety of what they know and have. But Americans will not jump helter-skelter into the unknown. See Klein, "The Lessons of '94," p. 3; Starr, "What Happened?" p. 21.

³³⁰ See Mark A. Peterson, "The Health Care Debate: All Heat and No Light," *Journal of Health Politics, Policy and Law* 20, no. 2 (Summer 1995): p. 426.

5. Failure to Question Underlying Assumptions

Furthermore, the task force did not question the assumptions that underlay managed competition. The premises that Americans were not sufficiently cost-conscious or that insurance companies were best suited to control health care were highly problematic. Despite paying only a percentage of the total cost, Americans were more concerned about the cost of health care³³¹ than almost any other facet of the health care system. When the task force accused Americans of not being cost-conscious because they did not pay enough of their own health care costs, advocates of managed competition were blaming the victim for problems they did not create.

Evidence that insurance companies were best suited to control costs and quality of care was dubious at best. At the time the task force was working to formulate Clinton's health care reform policy, more than eighty percent of the health care delivery system was under some form of managed care, contracted, controlled, and/or influenced by insurance companies. Yet, cost increases were approximately twice the annual rate of inflation. "This failure to control costs (but success in raising profits) was accompanied by an equal failure to improve the quality of care as insurers micromanaged the physician-patient relationship."³³²

The task force worked outside the spotlight, so the press was not privy to either the direction that health care reform might take or the process that decided that direction. Lacking solid information, journalists speculated on what might be taking place within

³³¹ Medical bills almost always indicate the total cost of treatment minus what (if anything) was paid by insurance, with the remainder as the responsibility of the patient. Thus, patients were very aware of the high cost of care.

³³² Funigiello, *Chronic Politics*, p. 232.

the task force and, inevitably, some of what was said in the press was erroneous. What the varying reports and speculation really emphasized, however, was how few final decisions had been made. As the president's self-imposed deadline approached there was nothing substantive to work with.

Nevertheless, Hillary Rodham Clinton began touring the country, to mobilize public support for the as-yet amorphous health care reform proposal, and put the health care crisis into human proportions. Visiting the states, Mrs. Clinton helped people understand that the health care crisis affected real people in real ways and showed that the administration was reaching out to the public for guidance in resolving a problem that several generations of lawmakers had not been able to solve. As her tour was gathering momentum, Hugh Rodham³³³ suffered a stroke and the First Lady returned to Little Rock.

When Mrs. Clinton returned to Washington she expected to finalize the work of the task force and forward the health care proposal to Congress for immediate action but the battle of the budget took precedence over new legislative proposals. Furthermore, because of major unresolved policy issues, the complexity of reforming health care, and the disagreements with the task force working groups, a meaningful time for a health care bill was no more than a guess.

6. Shortcomings of the Health Care Reform Proposal

A member of an audit team that reviewed the task force findings pointed out some of the shortcomings that would have to be corrected: “The proposal lacks a focus and

³³³ Hugh Rodham, Hillary Rodham Clinton's father, suffered a stroke on March 20, 1993 and died on April 7, 1993. See http://www.pbs.org/newshour/forum/may96/background/health_debate_page1.html.

identity that is presently missing. It tries to straddle the line between free-market competition and governmental bureaucratic regulation, but does neither one well.”³³⁴ The proposal was unnecessarily complex, expensive, and inefficient.³³⁵ It would not be easy to explain the proposal or communicate its merits to the American people or Congress.³³⁶

Yet, from the very beginning the working group on Health Care Communication Policy had advised the task force that health care reform had to pass through two distinctive phases. First, the White House — and only the White House — controlled the message. No one else, whether proponent or opponent of reform, advocate, legislator, or labor, could define the message on health care reform. This would involve a proactive strategy to create a constituency for the president’s plan and to bypass Congress if necessary and appeal directly to the American people. “Educating the public to the health care crisis, explaining simply and clearly the elements of Clinton’s plan, anticipating public reaction to it, and explaining how the government would ease the transition to the new health care system were essential components of that strategy.”³³⁷ After all the groundwork was complete, after the public was educated to the reality of both the health care crisis and the plan to resolve that crisis, then the president would go on national television to explain his plan “so that every American understood both the

³³⁴ Funigiello, *Chronic Politics*, p. 234.

³³⁵ See Starr, "What Happened?" p. 24.

³³⁶ The Clinton administration was making the same mistakes that had derailed past attempts at health care reform.

³³⁷ Funigiello, *Chronic Politics*, pp. 235-6.

need to spread the pain and the benefits of helping *all* Americans.”³³⁸ This would mean speaking very candidly about how the proposed system would provide a better quality of life individually and collectively. The president would also have to emphasize that his proposed plan did not deprive any individual or group of any benefit they already enjoyed. The focus would have to be on all Americans, not just the uninsured, and how all would benefit from the proposed plan. And the president would have to resist the urge to criticize a group such as the AMA.

7. The Administration Begins to Lose the Health Care Reform Battle

The administration lost the public relations battle to persuade Americans that the current health care system was in crisis. The public began to perceive the Clinton reform plan as a threat, rather than an enhancement, to their security. Whereas the recession of 1990-1991 left many if not most Americans terrified that they would lose their health care, “the Clinton bill promised that they would lose that care.”³³⁹ In the aftermath of the defeat of the Clinton plan, reformers began to promise the people that, if they were satisfied with their current health care, then nothing would change, but they could not make that promise in 1993-1994 because it was not true.

When the rough draft of the health care reform bill was complete, Magaziner and the First Lady went to Capitol Hill to brief members of Congress and their staffs. Up to this time, Congress had been left out of the loop. Time that should have been spent negotiating with Congress was instead spent developing a plan and drafting the legislation even though in America Congress, not the president, writes law. No time had

³³⁸ Funigiello, *Chronic Politics*, p. 236.

³³⁹ Klein, "The Lessons of '94," p. 3.

been spent building the coalitions that would have been needed to enact health care reform and no aggressive strategy for selling the plan, to Congress and the nation, had been developed.³⁴⁰

After Congress had been briefed, the still secret plan was leaked to the press and to anti-Clinton lobbying groups. Although the president's address to the nation was not scheduled until September 22, the Health Insurance Association of America (HIAA) began running the powerful "Harry and Louise" television ads, featuring the catchphrase "They choose, you lose."³⁴¹ Three days before the president's speech, Senator Daniel Patrick Moynihan (D-NY),³⁴² chairman of the Senate Finance Committee, appeared on "Meet the Press" and hinted that he might support a threatened Republican alternative proposal for health care reform, dismissed the as-yet-unannounced Clinton plan as a "fantasy," and undermined the efforts of all reformers by stating there was "no health care crisis."

8. President Clinton Introduces His Proposed Health Care Plan

President Clinton introduced his proposed health care plan to the nation and a joint session of Congress in a powerful speech infused with an almost wartime sense of

³⁴⁰ See Sven Steinmo and Jon Watts, "It's the Institutions, Stupid! Why Comprehensive National Insurance Always Fails in America," *Journal of Health Politics, Policy and Law* 20, no. 2 (Summer 1995): pp. 339-40; Starr, "What Happened?" p. 22; Klein, "The Lessons of '94," pp. 3-4.

³⁴¹ *Online NewsHour*, May 1996, PBS Forum, 15Aug2007
<http://www.pbs.org/newshour/forum/may96/background/health_debate_page1.html>.

³⁴² Moynihan replaced Lloyd Bentsen as Chairman of the Senate Finance Committee when Clinton appointed Bentsen to be Secretary of the Treasury. Bentsen had been a strong chairman, a dealmaker with lots of trust, strong ties to business, and tight control of his committee. Moynihan, on the other hand, a brilliant man who was a better thinker than legislator, was not a strong chair of the Finance Committee and he did not care much either about health care or for the Clintons. Clinton also lost a powerful ally when Dan Rostenkowski, Chairman of the House Ways and Means Committee, was indicted on 17 counts of fraud. His replacement Sam Gibbons, who lacked experience and deal making savvy, was not a strong chair for the powerful and necessary Ways and Means Committee. See Klein, "The Lessons of '94," p. 3.

urgency. The initial response was overwhelmingly favorable, as the President called for universal medical coverage for all Americans, promised every American the security of health care that would always be there, guaranteed every American a generous basic package of health care coverage, and “asked Congress and the American people to work with him to enact the most sweeping national program since Social Security in 1935.”³⁴³

After imploring Americans to seize the moment for reform, the president did not immediately follow up with the introduction of the legislation embodying the concrete details of his plan because he had, as yet, no bill to introduce.³⁴⁴ Instead, in the absence of the detailed plan, vested interest groups began to offer tentative support but at the same time to bargain for concessions in exchange for that support.

Within a week of the president’s speech, the First Lady spent several days giving testimony on health care before five separate congressional committees. Although her appearance was both dramatic and triumphant, its very success triggered intense opposition from those who considered her to be a threat to their vested interests. The President and First Lady began to make a number of appearances around the country to drum up support for the bill, but almost immediately the president’s attention was distracted by international crises, in Somalia, Haiti, and Russia, and by the problems with

³⁴³ Funigiello, *Chronic Politics*, p. 240.

³⁴⁴ At this point, the Clinton administration let the opponents of reform take charge of the message and the opposition framed the message in terms that would be most beneficial to them. The opposition introduced a cautionary note that made the public afraid of what the Clinton plan might do to them and what they might lose under the Clinton plan. This fear and uncertainty led the public to lose faith in the Clinton plan and this loss of face caused support for the plan to diminish. The opponents of reform got their message across to the public without ever disparaging the Clinton plan. In marketing terms, this is known as using the “FUD” — Fear-Uncertainty-Doubt — factor.

organized labor over the upcoming NAFTA vote.³⁴⁵ Nearly all presidential health care events scheduled for October were cancelled, and the administration lost the momentum gained from the President's September 22 speech and the First Lady's follow-up week of congressional testimony.

9. Health Care Bill Presented to Congress

The Health Care bill was finally presented to Congress on November 20, the last day of the 1993 session. In the two-month interval between Clinton's speech to the nation and the formal introduction of the legislation, the opposition organized and solidified. At the end of October the Republicans had made it very clear that they were unconditionally opposed to Clinton's health care reform proposal and would work to defeat, not amend, the legislation.³⁴⁶ The AMA at first cautiously professed willingness to cooperate with Clinton's plan but later was unusually reticent in regard to either supporting or opposing the legislation. The HIAA efforts, especially the continuing "Harry and Louise" ads,³⁴⁷ were so successful that it was able to expand its budget and launch an extremely successful grassroots campaign, producing nearly a half million contacts with Congress through phone calls, visits, and letters. In an unprecedented and

³⁴⁵ Much time and political capital was spent on issues and events that were not related to health care reform. Some were unavoidable but all consumed the scarcest of White House resources, presidential attention. See Klein, "The Lessons of '94," p. 2.

³⁴⁶ William Kristol, Republican Party political strategist, issued a memo in which he warned Republicans that a Democratic victory in regard to health care reform would save Clinton's political career and ensure Democratic majorities for years to come and urged Republicans to resist any desire to negotiate a compromise with the Democrats. His advice to Republicans was to resist any Democratic proposal, sight unseen. See Klein, "The Lessons of '94," p. 3; Starr, "What Happened?" p. 22.

³⁴⁷ With the "Harry and Louise" ads, the HIAA's public relations representatives found a way to bring scare tactics down to a level that people could understand and relate to. See Darrell M. West, Diane Heith, and Chris Goodwin, "Harry and Louise Go to Washington: Political Advertising and Health Care Reform," *Journal of Health Politics, Policy and Law* 21, no. 1 (Spring 1996): pp. 47-48.

scathing attack on the insurance industry, Hillary Clinton accused the industry of greed and deliberately lying about the Clinton plan in order to protect profits. The First Lady's assault on the insurance industry made front-page news and drew even more attention to the HIAA's message. The majority of Americans did not believe the "Harry and Louise" ads, yet these ads "helped frame Health Security in a way that shook public confidence."³⁴⁸ By the end of the year, the American people had little if any real knowledge about what the Clinton health care reform plan really entailed, yet they were increasingly fearful of what they had heard about it.

10. Big Business Support and Opposition

The business community had supported the idea of reform but was not necessarily supportive of the reality of reform as delineated in the Health Security legislation. Large corporations wanted government cost-containment regulations but did not want to give up either existing private market relationships or their own private health programs. In fact, once big business became aware of the details of the Clinton proposal, they feared, and thus were opposed to, specific aspects of it. For big business managers, the Clinton plan was needlessly complex, required a new federal bureaucracy, and threatened their own interest in the existing job-based system. They were angry that the administration had not taken their concerns seriously and had not drawn on the expertise they had acquired in their years of fighting to contain health care costs but they were not able to translate their general anxiety into either effective legislation or a cohesive message of opposition. Big business supported universal coverage and cost containment, the twin

³⁴⁸ Quadagno, *One Nation, Uninsured*, p. 190.

pillars of the Clinton plan, but the voice of big business was fragmented because they had no overarching organization that could convey one message with one voice and lobby effectively for the collective interests of the big business community. Thus, the support of big business was vulnerable to pressure from businesses that derived a competitive advantage from offering low benefits to employees and businesses like insurance companies and pharmaceutical companies that realized cost containment meant reduced profits for them.³⁴⁹

11. Small Business Opposition

Small business, by contrast, had no direct access to the federal bureaucracy but they did have representative associations, such as the National Federation of Independent Business (NFIB), to speak for them. Small businesses were looking for reform that would help them purchase group health insurance but they were adamantly opposed to any employer mandate. Speaking through the NFIB, small businesses voiced their objections to the Clinton health care plan, and the unified voice of small business came through much more loudly and clearly than the diverse messages from individual large corporations.

12. Organized Labor Support and Opposition

Organized labor was not of a single mind about health care reform and thus their support of Clinton's intent to reform health care and his specific plan for reform waxed and waned. Some unions were committed to a private sector solution for health care reform while other unions plus nearly all of the local leadership and rank-and-file

³⁴⁹ See Klein, "The Lessons of '94," p. 4.

members were committed to a single-payer system such as the Canadian health care system. After Clinton was elected, labor appeared to close ranks and promised to give the full support of organized labor to enacting his health reform legislation. However, the promised trade union support failed to materialize because organized labor was adamantly opposed to NAFTA, a move that they considered to be antithetical to their interests.

13. Average Americans

Average Americans had difficulty understanding the substance of Clinton's health security bill but they were constantly exposed to media advertising that focused on potential shortcomings of the plan and the possibility of losing what they had. Because the Health Security bill was more than a thousand pages long, most Americans did not read it. Instead, they got their information from media sound bites and their fears from the opposition's ad campaigns.

14. Middle-of-the-Road Strategy

With support for health care reform eroding, a middle-of-the-road strategy, the same type of strategy that contributed to the successes of Social Security, Civil Rights, Medicare, and Reagan's catastrophic insurance law, was needed. Each of these had become law because of a bipartisan majority of Senate Democrats and Republicans who represented the powerful consensus of the middle ground. Unfortunately, this kind of cooperation was not to be. Democrats were divided in their support for Clinton's health care reform legislation and Republicans were united in their intent to defeat it.

In July, with midterm elections looming on the political horizon, Senate Majority Leader George Mitchell and House Majority Leader Dick Gephardt introduced rescue

bills to try and salvage some remnant of health care reform. Under the compromise legislation, employers would be required to provide health insurance for ninety-five percent of the population by 2000, with the remaining five percent to be covered at some unspecified future time. In a major concession to small businesses, employers with twenty-five or fewer employees were exempt from providing coverage. The compromise bill also abolished Medicaid, rolling its recipients into the private sector.

Compromise legislation was a last-ditch effort to break out of the impasse and to forge a bipartisan compromise by proposing a voluntary system that was less bureaucratic and government-intrusive than the Clinton proposal and was built on the existing private insurance market. Mitchell and Gephardt introduced their respective bills in the Senate and House and scheduled debates with the intent of voting on the rescue bills after passing a crime bill.

At this point the Republicans, in the person of Newt Gingrich, struck by attacking not the rescue bill but the crime bill. His strategy was to defeat health care by blocking the crime bill. This was a “parliamentary tactic [that] would preclude a vote on the rescue bill, close down Congress, send legislators back to their home districts, and deny Democrats the opportunity to record a vote on health care reform before the fall elections.”³⁵⁰

House leadership tried to force the debate on health care reform by bringing the crime bill to the full House for debate and a vote but Democrats were deeply divided over

³⁵⁰ Funigiello, *Chronic Politics*, p. 255.

the bill.³⁵¹ Fifty-eight Democrats bolted their own party and voted with the Republican opposition, the crime bill was defeated, and any possibility of a health care reform bill in the House died at that point. Democratic leadership lost control of the House, effectively in August and actually in November.

The Senate passed the crime bill but was unable to make any headway on health care reform. In late August, Democratic leaders of both House and Senate gave up on health care reform and announced that Congress would recess for summer vacation. Neither the Senate nor the House had come close to passing or even voting on any health bill. When the Republicans gained control of Congress in 1994, Clinton adopted a shrewdly passive role, as the guardian and protector of Medicare and Medicaid and the other great Democratic social programs. And in spite of the defeat of the comprehensive health care reform legislation proposed by the Clinton administration, some aspects of the plan would become law.

H. Aftermath of Failure to Enact Health Care Reform in 1994

In August 1996, the Health Insurance Portability and Accountability Act (HIPAA), a bipartisan bill sponsored by Democratic Senator Ted Kennedy and Republican Senator Nancy Kassebaum, was passed. HIPAA “guaranteed that a person who currently had health coverage through his workplace could change jobs without fear of losing coverage.”³⁵² Although it was enacted in time for the November elections, HIPAA fell far short of Clinton’s promise of universal coverage, did little, if anything for

³⁵¹ Liberal Democrats, especially members of the Black Caucus, wanted to modify the crime bill’s tough death penalty provisions and conservative Democrats were adamantly opposed to the bill’s gun control provisions. See Funigiello, *Chronic Politics*, pp. 215-16.

³⁵² Funigiello, *Chronic Politics*, p. 276.

the more than forty million uninsured Americans, and failed to guarantee that coverage would be affordable.

In 1997, the State Children's Health Insurance Program (SCHIP) was enacted. SCHIP is a federal government program that gives matching funds to states in order to provide health insurance to families with children, to uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

Democratic Senator Ted Kennedy, in the aftermath of the failed Clinton health care plan, introduced a bill, modeled on a 1996 children's health insurance plan in Massachusetts, to provide health care coverage for the children of the working poor, the insurance to be financed by an increase in the cigarette tax. President Clinton proposed the children's health insurance initiative in the State of the Union address in January 1997 and Republican Senator Orrin Hatch joined Kennedy as a co-sponsor of the legislation in March 1997. The original bill was defeated in May 1997 and revived a month later by Kennedy and Hatch. Many organizations, including the Children's Defense Fund and the Girl Scouts, lobbied its passage, putting public pressure on Congress. The bill passed Congress on this second attempt and was signed into law in August 1997, to take effect in September.

SCHIP, like Medicaid, is a partnership between federal and state governments. States have flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. The programs are run by the individual states according to requirements set by the federal Centers for Medicare and Medicaid Services (CMS).

Although it took some time and effort to get children enrolled, about one million children were covered by SCHIP after two years of the program. In 2007, ten years into

the program, between five and six million children were covered by SCHIP. There were two attempts to expand SCHIP in 2007, but President George W. Bush vetoed both. In early 2009, after President Barack Obama's inauguration and with strong Democratic majorities in both houses of Congress, legislation expanding SCHIP to cover about four million additional children, the expansion to be funded by another increase in the cigarette tax, was enacted and President Obama signed it into law.

Although HIPAA and SCHIP fall far short of universal access to comprehensive health care, both represent steps forward in America's social welfare policy. SCHIP works to reduce the number of uninsured children, but there are still millions of children who have no health insurance, in part because many have not yet been enrolled and in part because many employers have dropped coverage for dependents.

The cost of health care continued to grow, the quality of health care continued to deteriorate,³⁵³ and the number of uninsured rose as employers sought to control costs by terminating employees and rehiring them as contract workers who did not receive health care benefits. In May 1999, the "National Coalition on Health Care, a bipartisan group headed by former Presidents Bush, Carter, and Ford, reported on the erosion of health coverage but the report made barely a ripple."³⁵⁴ The report concluded that, even if the prosperity of the 1990s were to last for another decade, nearly fifty-five million — one in five — nonelderly Americans would still be without health coverage. The number would

³⁵³ The standards for measuring quality of health care are infant mortality and life expectancy. In the first decade of the twenty-first century, the United States fell below the median for developed countries in both infant mortality and life expectancy. See Funigiello, *Chronic Politics*, pp. 286-87.

³⁵⁴ Funigiello, *Chronic Politics*, p. 282.

increase to more than sixty million — one in four — Americans who would be without health coverage in a recession.

In spite of the report, health care reform was not a prominent issue in the 2000 presidential campaign because the political and popular will to find a solution to the problem was lacking. However, health care reform was definitely on the agenda during the campaign for the 2008 presidential election,³⁵⁵ leading to the introduction of health insurance reform legislation in 2009 and a nearly year-long debate that culminated in the successful enactment of the legislation in March 2010.

I. Barack Obama and Organizing for America: 2009-2010

In March 2010, President Barack Obama and a Democratic Congress succeeded in enacting legislation to overhaul the American health care system. This represents a significant first step on the road to reform, but it is just the first battle, although a decisive one, in the long war toward achieving comprehensive reform. Much work remains to be done between the passage of the bill and the implementation of the rules, regulations, guidelines, policies, standards, and oversight that will be necessary in order to insure that the reforms are implemented as they should be to provide universal access to an affordable health care system. Passage of the bill means that a sufficient number of Senators and Representatives were willing to vote in favor of the legislation but it does not mean that these same Senators and Representatives or the voters will remain committed to the cause of health care reform. Thus the need for activism in support of the cause of health care reform must continue.

³⁵⁵ Talking about, or even promising, health care reform in a campaign speech is not the same as enacting health care reform once elected. The possibility of substantive reform is problematic at best, with the economy in a serious recession and the continuing cost of waging war on two fronts.

Much of the work of activism was done through Organizing for America, a political movement that appeared to be a social reform movement. Organizing for America (OFA) was a continuation and reinvention of the Obama for America campaign that swept Barack Obama into office with a large popular majority and a significant Congressional majority. In some respects, OFA did work comparable to a social reform movement such as calling and writing Senators and Representatives, assisting in organizing and conducting town hall meetings, and gathering the personal stories of people who have suffered because of the current implementation of the American health care system. However, it was not a true social movement focused on the need for reform but was instead a political movement focused on garnering sufficient votes to enact specific legislation. Once the health insurance reform legislation was passed, OFA moved on to other issues and is no longer concerned with health care reform.

Thus, it falls to American activists to continue the work of social reform, to persuade the American people of the continuing need for reform, to engage the minds and hearts of the American people so thoroughly that they will settle for nothing less than comprehensive reform, universal access to affordable health care. The organization of a social reform movement in conjunction with the commitment of the American people will ultimately compel the government to act in accordance with the will of the people. Thus, although the importance of the successful enactment of health insurance reform legislation must not be denigrated, the need for a social movement to complete the reform of the American health care system may be more important now than ever before.

III. Lessons from Past Successes

A. Social Security and Medicare: Paradigms of Successful Social Legislation

Of all the attempts to enact comprehensive social legislation in America, several of which are discussed in detail in this chapter and many more of which are left out of the discussion, only two were successful: Social Security and Medicare.³⁵⁶ Why were these efforts successful when so many others failed? Several similarities can be identified between the Roosevelt administration, responsible for Social Security, and the Johnson administration, responsible for Medicare.

First, both Roosevelt and Johnson were social liberals,³⁵⁷ affiliated with the Democratic Party.³⁵⁸ Both were popular and were elected by large majorities.

Second, both Roosevelt and Johnson had the benefit of working with Democratic majorities in both houses of Congress.³⁵⁹

³⁵⁶ The March 2010 enactment of Health Insurance Reform legislation certainly counts as a success but is not considered in this discussion for two reasons: there has been and will be no extended discussion of the legislation, the struggle to enact it, or the details of what is included in the legislation and there has not been sufficient time to evaluate the efficacy of the newly-enacted legislation. Thus, in the context of this dissertation, only Social Security and Medicare/Medicaid are considered to be successful attempts at enacting major social reform legislation. The discussion of the success of the March 2010 health insurance reform legislation must be deferred until a later time.

³⁵⁷ Social liberals contend that society must protect liberty and opportunity for all citizens and that the state not only may, but also frequently must, have a role in this. For social liberals, the lack of education, health, employment, or security in retirement is seen as a major threat to the freedom of the state. Because the lack of positive rights, such as economic opportunity, education, health-care, retirement security, and so on, can be considered to be threats to liberty, social liberals believe that the state has the obligation to guarantee these positive rights.

³⁵⁸ Successful social welfare legislation does not depend on the Democratic Party. However, the two major successes in enacting social welfare legislation in the United States occurred when the Democratic Party was in control of both the executive and legislative branches of government.

³⁵⁹ It is, obviously, not necessary that the majority party in Congress be Democratic. It is necessary, however, that the majority party in Congress be the same political party and political ideology as the executive branch.

Third, Congress, in particular Congressional Democrats, was unusually cooperative with both Roosevelt and Johnson. This is not to say that either had an easy time in dealing with Congress. However, the Congressional Democratic majorities were large enough to overcome the opposition of both Republicans and conservative southern Democrats.

Fourth, both Roosevelt and Johnson were elected in times of crisis.³⁶⁰ Roosevelt had to jump-start the economy during the Great Depression before moving on to significant social legislation. Johnson had to calm the fear engendered by the assassination of President Kennedy before creating his own domestic policy agenda. Thus, both Roosevelt and Johnson had time both to establish a solid working foundation with Congress and to engender confidence in the American people before proposing comprehensive social welfare legislation.

Fifth, neither Roosevelt nor Johnson proposed legislation that could be perceived as a dole or a handout. Recipients are entitled to both Social Security and Medicare because they earned both, by paying taxes all of their working lives.

Sixth, both Roosevelt and Johnson were consummate politicians who understood the legislative process and never proposed legislation that had no chance of being enacted.

³⁶⁰ President Barack Obama also assumed the presidency at a time of grave economic crisis. Thus, if a climate of crisis works to advance social welfare legislation, he may be able to accomplish the health care reform that has eluded others for the past century. However, like FDR at the time of the Great Depression, President Obama will have to jumpstart the economy before he can move on to social welfare programs.

Seventh, the American people were actively involved in making their priorities known to the administrations, over and above exercising their votes.³⁶¹

During the Great Depression, the need for social welfare legislation was visible and obvious. Economic refugees filled the highways and cities; the hungry waited in long bread lines in order to get food to eat; the unemployed rioted in frustration; the homeless improvised tent cities to have a roof overhead. In general, the victims of the Great Depression were neither organized nor demonstrative³⁶² but they were omnipresent, a living reminder of the need for social welfare reform.

During the 1960s, the era of Medicare, the elderly organized into social action groups.³⁶³ Building on the success of the Civil Rights activists, the elderly initiated letter-writing campaigns, demonstrations, and rallies. By their activism, the elderly spread their message far and wide, to everyone who wanted to hear it. There was no doubt about what was wanted — health care — or who wanted it — the elderly. Such was the focus of the senior movement that no Congressman or Senator — Republican or Democrat — who supported Medicare was defeated in the 1964 election.

³⁶¹ In the 1920s and 1930s some fringe social movements, directed primarily toward the elderly, began to draw attention to the plight of the elderly and work to gain pensions for them. Much of the social movement work was concentrated in California, the nation's retirement capital at that time. The most exotic movement was the Ham and Eggs movement which promised thirty dollars a week in scrip to unemployed California voters aged fifty and older. Other Depression-era social movements that offered unorthodox economic proposals included Upton Sinclair's End Poverty in California (EPIC) movement, Huey Long's Share-Our-Wealth Clubs, and Alberta's Social Credit movement. One movement that built a national following was the Townsend Movement that promised a pension of two hundred dollars a month to those sixty and over. For more information on Depression-era social movements, see Daniel J.B. Mitchell, *Pensions, Politics, and the Elderly: Historic Social Movements and Their Lessons for Our Aging Society* (Armonk, NY: M.E. Sharpe, 2000).

³⁶² Protest demonstrations would not become a fixture of American culture until the 1950s and beyond.

³⁶³ The National Council of Senior Citizens (NCSC), organized by the AFL-CIO, was one such group and it was very active and successful in the fight for Medicare. The NCSC was also active in the repeal of the Medicare Catastrophic Coverage Act.

None of the similarities between the two successful paradigms of social welfare legislation is sufficient by itself and some are more necessary than others. For example, even a popular president with a Congressional majority will probably not succeed if that president consistently submits legislation that is beyond the bounds of what Congress, as representatives of the American people, will accept. Part of the President's ability to influence Congress comes from knowing what to ask, and how and when to ask it. Sheer determination, in the manner of Truman, is not enough; finesse is also necessary. Both Roosevelt and Johnson demonstrated this, Johnson even more so than Roosevelt, probably because of what he learned during his long career as first Congressman and then Senator.

As important as it is for the President and Congress to cooperate in enacting legislation for the American people, it is equally or even more important for the American people to be active in promoting what is important to them. The people were visible during both eras that resulted in comprehensive social welfare legislation, unwillingly and without organization during the Great Depression and deliberately and with organization during the 1950s and early 1960s. Their activism informed legislators beyond a doubt what was wanted. The lesson of activism is a significant lesson for the future.

B. Barack Obama and Organizing for America

It is too soon to comment on the success of the recently enacted legislation, but two significant similarities can be drawn between the contemporary situation and previous successes. First, the President and a significant Congressional majority were Democratic. Second, the American people were actively involved in calling for reform.

Thus, the need for President and Congress to be cooperative members of the same political party and the need for active American involvement in the cause of reform both appear to be important for, if not prerequisite to, the cause of reform.

IV. Lessons from Past Failures

A. Truman, Nixon, and Clinton

1. Political Dimension of Health Care Reform

Although the attempts to accomplish health reform under Truman, Nixon, and Clinton occurred at different times, under different circumstances, and in different political climates, several lessons can still be drawn from these efforts. One major lesson, for example, something that did not seem to be understood by any of the reformers at the time, is that health care reform is, first and foremost, a political issue, not a medical issue.³⁶⁴ This same mindset appears to have been carried forth into the attempts to accomplish health care reform under both Nixon and Clinton. In the 1970s, politicians seemed to be intent on outmaneuvering one another, forgetting that part of politics is to persuade the American people to support the planned legislation.³⁶⁵ Clinton

³⁶⁴ Oscar Ewing, head of the Federal Security Agency (FSA) and advisor to Harry Truman on health care and other social issues, thought that the drafters of the health security legislation were excellent technicians but naïve in not understanding that health security was a political issue, not a medical one. Had Ewing drafted the Truman legislation, he would have, for example, allowed the pharmaceutical industry to set drug prices to neutralize it in the fight with the AMA, with a provision for the government to intervene if there was evidence of price gouging. See Funigiello, *Chronic Politics*, p. 315, n. 15.

³⁶⁵ A comparison that comes to mind is that of a politician who announces that s/he will be a candidate for office then ignores the public and still anticipates victory on Election Day. Campaigning — persuading the American people to support the candidacy or the legislation — is an integral part of the American political process. Opponents of health care reform recognized this and acted on it in 1948 and in every subsequent bid for health care reform. Proponents of reform have not yet recognized or understood the importance of selling the idea to the American people. It should be noted that Jack Cartenson, the head of the NCSC who organized the senior citizens into an active, cohesive and successful social movement that contributed to the success of the Medicare legislation, was known to be both a salesman and a showman.

broke his own first rule, that good policy is impossible without good politics.³⁶⁶ The Clinton administration seemed to be so caught up in their own vision of what the American health care system should be that they neglected to keep Congress in the loop, neglected to keep the media informed, and, most serious of all, neglected to win the hearts and minds of the American people. Thus, the first major lesson for future reformers is to recognize and honor the political dimension of health care reform.

2. The Art of Compromise

During the Nixon presidency and again in the Clinton years, there was seemingly no understanding of the art of compromise. At both times, reformers advocated the same goal, universal coverage that embodied quality care and controlled costs, but differed on the means to accomplish that goal.³⁶⁷ In the 1970s, advocates of comprehensive health care dissipated their energies in support of three plans: government-operated health insurance, employer-mandated provision of private insurance, and catastrophic insurance. In the early 1990s, reformers were again divided, this time among single-payer, pay-or-play, and managed competition. Because of an inability or unwillingness to compromise, advocates of health care reform were not able to build coalitions and reach consensus on how to proceed. Thus, these two attempts at accomplishing comprehensive health care

³⁶⁶ In his autobiography, President Clinton admits that one of the things that caused him to lose his first bid for reelection to the governorship of Arkansas was that he forgot the political dimension of making policy. He made the same mistake in attempting to reform the American health care system during his first term as President. See William Jefferson Clinton, *Bill Clinton: My Life* (New York, NY: Alfred A. Knopf, 2004), Chapter 21.

³⁶⁷ During the Truman presidency, the disagreement was not so much on what type of reform to endorse but rather was on which agency would control the new health insurance system. A classic turf war erupted among the agencies vying for control, especially the Federal Security Agency (FSA), the Veterans Administration (VA), and the Social Security Administration (SSA). Thus, each agency refused to endorse any idea or plan formulated by a rival agency, for fear that the endorsement would be interpreted as a willingness to cede control to that agency. See Funigiello, *Chronic Politics*, Chapter 3.

reform failed because advocates disagreed over the means even though they agreed on the ends. While the proponents of reform were divided, the opponents, as always, were united in their opposition, well-financed, and willing to commit resources to block reform. The second major lesson from past failures, therefore, is not only to recognize the need for compromise but also to practice the art of compromise.

3. Educating the Public

Neither Truman nor Nixon nor Clinton put any significant effort into educating the public on the need for comprehensive health care reform and thus building the grassroots support that might have made the difference in effecting reform. In each case, but particularly so in the case of Truman and Clinton, the opponents of reform took control of the debate and painted such a negative picture of health care reform for the American people that whatever support for reform might have existed quickly waned. During the Nixon administration, when Congress was more predisposed than it ever had been to legislate national health insurance, there was little public demand for health care reform. Few politicians received any mail on the subject of health insurance from their constituents, suggesting a distinct lack of public interest.³⁶⁸ A third major lesson from the past failures to enact health care reform legislation is the importance of building and maintaining public interest and grassroots support for reform.

³⁶⁸ For a more complete explication of the attempts to institute national health insurance during the Nixon era, and in particular on the lack of grassroots support for health care reform, see Quadagno, *One Nation, Uninsured*, Chapter 5, pp. 110-24.

4. Concatenation of Errors

During the Clinton era in particular, there seemed to be a concatenation of errors that doomed the effort to enact health care reform to failure. The existence and secrecy of the Task Force worked against the administration because the American people were predisposed to distrust secret government actions.³⁶⁹ The involvement of the First Lady created problems because, although she may have been the very best person to do the work, there was confusion over her public and private persona, confusion that undermined the work of health care reform. The White House doing the work of drafting the highly complex legislation without involving Congress or the Congressional committees was a major blunder. Presenting the complex legislation to Congress as though it were a *fait accompli* and neglecting the fine art of negotiation,³⁷⁰ the negotiation that would necessarily take place during the drafting and subsequent Congressional mark-up period, was another error. Neglecting to explain the complex legislation in terms the American people could understand was yet another in the concatenation of errors. The Clinton administration also neglected to understand what the public really wanted (better access and lower cost) and failed to win the hearts and minds of the American people and to build the grassroots support that would be necessary to accomplish health care reform. Further, the Clinton administration allowed the opponents of reform to take control of the

³⁶⁹ After nearly a half-century of conspiracy theories, from McCarthyism in the 1940s and 1950s, to the assassinations (JFK, Martin Luther King, Jr., Bobby Kennedy) in the 1960s, to Watergate in the 1970s, to Iran-Contra in the 1980s, Americans assumed that government secrecy meant a cover-up. Trust, once lost, is not easily regained.

³⁷⁰ The Clinton administration presented the Health Security Bill to Congress, apparently expecting that the bill would be passed without modification. This is equivalent to opening a contract negotiation meeting by present the BAFO (Best And Final Offer) and handing the client a pen with which to sign the contract. This is not the way contracts are negotiated in the business world and it is not the way legislation is enacted in Congress.

message and thereby to control the debate over health care reform. Opponents of reform succeeded in planting the seeds of fear, uncertainty, and doubt in the minds of Americans and these seeds grew into distrust of the poorly understood Clinton plan and ultimately into lack of support. And, in addition to all the other errors, large and small, that were made by the Clinton administration, they were also overly optimistic about how much could be accomplished in a very short time.³⁷¹ Among lessons to be learned from the failure to enact comprehensive health care reform during the Clinton era are the necessity of establishing a realistic timetable, the necessity of working with Congress in writing legislation, the necessity of ensuring that the plan for reform addresses the real needs of the American people, the necessity of building grassroots support for the plan, and the necessity of keeping the plan simple, easy to explain and easy to comprehend.

Thus, much can be learned from past failures to effect comprehensive reform of the American health care system. Future reformers would do well to learn from the errors of the Truman, Nixon, and Clinton administrations.

V. Lessons for the Future

A. Role for the American People

The American people — the uninsured, the underinsured, and the fully insured whose out-of-pocket expenses are growing out of control and whose fear of becoming suddenly uninsured continues to escalate — are the ones most affected by the lack of government-sponsored national health insurance. If the people seriously want and need this social welfare program, then it would be in their best interest to pursue the goal of

³⁷¹ For greater detail on the errors made during the Clinton administration's attempt to enact health care reform, see Klein, "The Lessons of '94."; Starr, "What Happened?"

health care reform actively and vigorously.³⁷² In studying and understanding the history of social legislation in general and health care reform in particular, some lessons from the past can be learned and some lessons for the future can be formulated.

1. Right Political Climate

One lesson from the past two successes, Social Security and Medicare, is the importance of the right political climate for effecting comprehensive reform. In 1935, and again in 1965, a liberal President affiliated with the liberal political party worked with a cooperative Congress, the majority of whom were liberals affiliated with the same liberal political party.³⁷³ While this combination may not be an absolute requirement for effecting social reform, it is not unreasonable to assume that a comparable political climate would be more likely to draft and enact legislation that not only would provide the American people with the security of universal access to comprehensive health care but also would stand up in court. Only when the right people are in office, at the local, state, and national levels, people who are committed to reform,³⁷⁴ willing to listen to the

³⁷² It is possible that health care reform legislation could be enacted without a social movement dedicated to the reform of the American health care system. However, a social reform movement may be the extra-added ingredient that helps to overcome the status quo and enact the reform legislation that has been so elusive for the past century.

³⁷³ In the 1930s and again in the 1960s, the Democratic Party controlled both the executive and the legislative branches of government. In both cases, the President and the majority of Congress were liberal Democrats. It is probably more important that they were liberals than that they were Democrats although in contemporary American politics liberalism is usually associated with the Democratic Party.

³⁷⁴ It might be underlining the obvious to include this note but the elected representatives of the American voters cannot and must not be indebted to the health industry's special interest groups. Politicians who have accepted large campaign contributions or other gifts from, for example, HIAA or pharmaceutical industry lobbyists will most likely not vote for any law that would adversely impact the health insurance or pharmaceutical industries. Thus, politicians who are beholden to the special interest groups should not be considered acceptable candidates for office.

voters, and able to cooperate and compromise with one another, and to put the common good ahead of the individual, will there be a reasonable chance to make reform happen.

2. Finding and Electing the Right Candidate

If the ability to effect significant social reform depends on the combination of a President who favors such reform working with a cooperative Congress that also favors such reform and is willing to support the President's agenda, then it is the responsibility of the people to find appropriate candidates and elect them to office. In selecting appropriate candidates, it might be wise to look for those who embody the beliefs and characteristics of the great social reformers of the past.³⁷⁵ Theodore Roosevelt, for example, a Progressive Party candidate who was the first candidate to support social welfare legislation including health insurance for all Americans, believed that no country could be strong if its people were sick and poor. Franklin Roosevelt, the first President willing to involve the federal government in economic and social welfare problems, believed that the needs of the people were the nation's highest priority. Harry Truman, the first President to introduce health care reform legislation to guarantee universal access to comprehensive coverage for the American people, believed that the key to the nation's strength lay in the ability of its people to participate in democracy, something they could do only if they were healthy and physically sound. Lyndon Johnson, the only President to succeed in enacting health care reform legislation, although for only a segment of the population, believed that it was the responsibility of the federal government to change the

³⁷⁵ Abraham Lincoln, the first Republican President, presided over the first great social reform legislation in American history. In a different age, he might have supported health care reform legislation to guarantee access to health care for all Americans. He believed it was the fundamental duty of a democracy to lift all artificial burdens from its citizens and to elevate the condition of all. See Doris Kearns Goodwin, *Team of Rivals: The Political Genius of Abraham Lincoln* (New York, NY: Simon & Schuster, 2005), Chapter 3.

lives of Americans for the better by enacting comprehensive social welfare legislation including guaranteed access to comprehensive health care. Richard Nixon, the only Republican President to initiate health care reform legislation, was opposed to compulsory federal health insurance but was willing to support reform legislation because he understood, because of his family's experiences, the heavy burden that serious illness imposed on families. Bill Clinton was committed to protecting America's existing social welfare policy and to expanding it to include universal health care.

All of these great reformers, whether successful in legislating reform or not, embodied an eagerness, or at least a willingness, to put the needs of the American people ahead of those of the special interest groups. Thus, in searching for candidates to move the cause of health care reform forward, it would be advisable to find those who are also eager, or at least willing, to put the needs of the American people ahead of the health industry special interest groups. Once the candidates have been selected, it will be the responsibility of the American people to vote them into office. The right to vote, however, is taken for granted by nearly all Americans, who do not understand that the right to vote carries with it a corresponding duty to vote, and an implied responsibility of choosing the right candidate.³⁷⁶ Electing the right people to office entails more than merely making a choice through the ballot box, however. The Americans who want the right people to be elected will have to let go of their apathy and passivity, seek out and find the right candidates, and work to make sure that these candidates are actually

³⁷⁶ Americans neglect their right to vote for often-superficial reasons. Rain on Election Day, for example, almost always reduces the number of citizens who will go out to vote. The attitude that a single vote doesn't count is ignoring the fact that every vote is a single vote and many single votes are needed to accomplish anything substantive.

elected. This means getting out the vote — cajoling, coaxing, encouraging, persuading, or otherwise convincing family, friends, colleagues, neighbors, and strangers to vote.

Electing the right combination of President and Congress³⁷⁷ is only the beginning of the reform battle; it is an important first step, but not in itself sufficient to win the war. Therefore, it is necessary to look further at the history of social reform, and learn from the success of the opponents of reform, the health care reform efforts that failed.

B. Learn from the Opponents of Health Care Reform

In examining past efforts, it is obvious that one group has been extraordinarily successful in preventing health care reform: the health care providers. First the AMA and later the HIAA orchestrated and carried out the opposition to reform legislation. Since they were so successful in achieving their goal of preventing health care reform, it is important to understand their strategy and tactics, and to adapt and adopt them toward achieving the goal of enacting health care reform.

1. Grassroots Organizations

Americans who are committed to health care reform should affiliate with others who have the same interests in grassroots organizations, to share interests and ideas, gain support, and develop some ability to influence the issue. A grassroots organization can present a united face and a coherent message.³⁷⁸ Grassroots organizations can also

³⁷⁷ Or state legislature and governor or council and mayor — any and every level of government is capable of effecting some type of positive social reform. For this dissertation, the focus is at the federal government level.

³⁷⁸ The AMA almost always spoke with one voice, the voice of the powerful organization, not the voice of the individual physician. During the Clinton era, small businesses spoke with one voice through the NFIB, whereas big business did not. The united voice of small business prevailed over what could have been the far more powerful voice of big business.

organize and sponsor demonstrations, rallies, conferences, letter-writing programs, and other means of getting the message out and building support among other citizens.

Furthermore, a grassroots organization is close to the community and therefore close to the people who would benefit from reform. Members of the grassroots organization can speak to the community in terms that the community can understand and in the process educate them about the need for health care reform and how to accomplish it.

2. Learn to Speak with One Voice

It is also important for grassroots organizations to learn to speak with one voice. The AMA, except for a brief period in 1937, presented a united front and proclaimed a single message, spoken with one voice. Whereas the AMA had means of keeping its members in line, grassroots organizations will have to learn to compromise, reach consensus, and build coalitions. Lacking the financial resources of the AMA and other health care groups, grassroots organizations will have to rely on energy, enthusiasm, and hard work to get their message across to everyone.³⁷⁹

3. Put a Face on the Issue of Health Care Reform

Early on, it would be beneficial for reformers to put a face on the issue of health care reform. People identify more easily with a specific person than with a complex idea or set of statistics. Rosa Parks³⁸⁰ and Martin Luther King, for example, represented the Civil Rights movement. In California, Cesar Chavez was the face of the migrant

³⁷⁹ Grassroots organizations should also learn to capitalize on the expertise of their membership and utilize each volunteer's experience to further the cause.

³⁸⁰ Not everyone could relate to the brutal reality of segregation and Jim Crow, but anyone who worked all day and hoped to get a seat on the bus ride home could understand why Rosa Parks did not want to give up her seat and could empathize with all the tired workers who boycotted the buses.

workers. During the Clinton administration, the opponents of health care reform, specifically the HIAA, used the “Harry and Louise” television ads to give a face to the fear of reform. The ads, though not believed by the American people, created enough of a climate of fear, uncertainty, and doubt for the American people to withdraw their support for the need for health care reform. Americans who were unfamiliar with the proposed legislation were very aware of the message conveyed by Harry and Louise.

4. Define a Simple, Understandable Proposal for Reform

The work of the grassroots organization ought to be to define a simple straightforward proposal for health care reform. It would probably be best not to be too specific in terms of a detailed plan for health care reform. Rather, a simple statement, for example that an acceptable level of reform would be to provide universal access to all Americans for basic preventive and therapeutic medical services, would be preferable to a complex proposal that tried to address every individual or special case.

After developing such a plan, it will be important for the grassroots organization to share their plan with other grassroots organizations. This is important for building consensus toward what will be acceptable at a state or national level. Understanding the differences in the plans developed by other organizations is key to understanding the art of compromise. Compromising with other organizations can lead to coalitions that will be stronger because multiple voices have a synergistic effect in the marketplace.³⁸¹

³⁸¹ One reason for the failure of the 1974 and 1993 health care reform drives was the inability of the proponents of reform to compromise, reach consensus, and unite behind a particular plan for reform. In the 1970s, advocates of comprehensive health care dissipated their energies in support of 3 different plans: government-operated health insurance, employer-mandated provisions of private insurance, and catastrophic insurance. In the early 1990s, reformers again divided, this time among single-payer, pay-or-play, and managed competition. Thus, health care reform failed because its advocates disagreed over means rather than ends whereas opponents of reform were unified in their opposition.

C. American Activism

American activism has been getting results for more than a century. American activists formed the first unions, helped improve conditions for workers in factories and sweatshops, and forced safety standards to be developed and adopted. American activists were instrumental in getting America out of the war in Vietnam, in encouraging the women's movement, and in advocating for patients' rights. American activists helped to repeal Jim Crow laws and enact Civil Rights legislation. American activists are a force to be reckoned with, a force for change, and a powerful voice of the people. When the power of American activism is harnessed to the need for health care reform, change will almost certainly happen.

What emerges from a study of the history of social welfare legislation and health care reform in America is a stark realization of just how powerful special interest groups are and how much influence they have on the American democratic process. These special interest groups will not easily give up a system that is so lucrative and so beneficial to them.

However, if enough Americans are willing to band together in citizen or community action groups, they could be powerful enough to counteract the special interest groups. If progress is to be made, the American people will almost certainly have to be very actively involved.

1. Legitimate Role for the Government

Deeper levels of reform are needed in addition to health care reform,³⁸² but these reforms are beyond the scope of this dissertation. The health and well being of millions of Americans are at stake in this effort to reform health care. The problem is so large and so pervasive that it needs control at the federal level, although the states must be actively involved in administering the system. The American health care system is a national problem that can only be resolved with a national solution.³⁸³ This is not to say that the federal government should take over the American health care system. Rather, the federal government should oversee the creation and enforcement of strong regulations to ensure that all parties to health care are following both the letter and the spirit of the still-to-be-enacted health care reform legislation. The federal government has a legitimate role to play in establishing global budgets and negotiating fee schedules, in establishing a financing system for health care is sufficient and available, and in assuring that every American has access to affordable health care services.

³⁸² Two such reforms in the political process are a reform of the election process, so that candidates will not be so beholden to the special interest groups who contributed the funds to get them elected and a reform of the budget allocation method, from the current open system to a closed system. In addition, the American education system must be reformed so that generations to come have the tools they need to continue learning and to cope with a rapidly changing world. It has been said that education is learning to use the tools that society has deemed necessary and the American education system must be changed so that it once again lives up to that statement. The question of which reform should be given priority is somewhat like the problem of the chicken and the egg. Advocates of health care reform most probably believe that health care reform should be given highest priority, but health care reform might not be possible without an educated electorate and/or an election process free of the influence of special interest groups.

³⁸³ There is no historical proof for the superiority of either government regulation or market competition in achieving optimal performance in a health care system. See Theodor J. Litman, "The Relationship of Government and Politics to Health and Health Care -- A Sociopolitical Overview," in *Health Politics and Policy, 3rd Edition*, ed. Theodor J. Litman and Leonard S. Robins (Albany, NY: Delmar Publishers Inc., 1997), Chapter 1, p. 39.

The paradigm for a federal system is Medicare. For all its flaws, it works, and it delivers a reasonable level of health care to millions of Americans with a very low rate of administrative overhead. Medicare's overhead is the lowest of any health care provider in the United States.

Medicaid, on the other hand, enacted at the same time as Medicare, but as a state-controlled system, is chronically in trouble. States regularly cut Medicaid budgets as their own state revenues fluctuate. Eligibility requirements vary from state to state, and from year to year within the same state.

The two most successful attempts at enacting comprehensive social welfare legislation in the United States, Social Security and Medicare, are both federal programs. When health care reform joins the ranks of successful social welfare legislation, it should stand beside Social Security and Medicare as another federal program.

VI. Conclusion

A century after social reform was first attempted, there are still significant gaps in American social welfare legislation. One huge gap is the absence of universal health care, a benefit guaranteed to all residents in every other industrialized democracy. Some of the reason for this lack of health care insurance can be laid at the feet of the medical profession and health provider industry, the AMA at first, and later the HIAA.

Adamantly opposed to health insurance and what they perceived to be government interference in the doctor-patient relationship, the AMA successfully defeated virtually every attempt at health care reform. In the process, they gained "a Pyrrhic victory but

lost the war.”³⁸⁴ Too shortsighted to see beyond the immediate threat to their autonomy, the AMA now faces the worst of both worlds, with government and private managed care interference in the practice of medicine and no significant organized way to provide physician input into the system. It remains to be seen whether the medical profession will cooperate in a partnership with government, or continue to stick its head in the sand as it has done in the past. Physician leadership in a health care reform effort could make a difference in raising the stakes on enacting legislation.

On the other hand, the AMA does not bear the full brunt of responsibility. The American people, most affected by the lack of guaranteed health care insurance, have been too passive toward their own needs, too apathetic toward initiating and supporting reform, and too focused on individualism to understand that what affects the community in the short run will affect the individual in the long run. Enlightened self-interest says that the only way for the individual to protect his/her own access to health care is to ensure that everyone has access to health care.

American apathy must be transformed into American activism to initiate and accomplish necessary reform. American activism has changed the course of history in the past and it can do so again in the present. If it were not for the efforts of committed social reformers actively working to abolish slavery, America would have been a slaveholding nation well into the second half of the twentieth century at least and possibly even beyond that. And it was because of the work of a small group of

³⁸⁴ Norbert Goldfield, "The AMA Faces Down FDR and Wins," *Physician Executive* 19, no. 1 (Jan-Feb 1993): p. 1.

determined social reformers that American women won the right to vote and many other rights as well.

Since a century of effort at the political level to reform the American health care system has not yet succeeded in accomplishing a national health insurance system that provides universal access to comprehensive health care, it is necessary to consider an alternative means of accomplishing reform, a social reform movement, as the next logical step. Before launching a health care social reform movement, however, it is appropriate to learn as much as possible from the great social reform movements of the past. Therefore the succeeding chapters of this dissertation will examine social reform movements in general, and Abolition and Woman Suffrage in particular, to draw lessons and suggestions from those movements and then apply the lessons and suggestions to a Health Care Reform movement.

Part Three: Reform

Chapter Five:

Social Reform Movements

Chapter Six:

Abolition as a Social Reform Movement

Chapter Seven:

Woman's Rights and Suffrage as a Social Reform Movement

Chapter Eight:

Health Care as a Social Reform Movement

Chapter Five

Social Reform Movements

I. Introduction

A. **Recap of Parts One and Two**

1. Part One

Part Three of this dissertation will focus on Reform, social reform in general and reform of the American Health Care System in particular. Reform is necessary because a right, the moral right to health care, has been and is being violated. Part One of this dissertation, Justice, supported the idea that Americans have such a moral right to health care. Since this right is not being honored, then justice demands that the violation be redressed. Part of the effort to redress the rights violation must be to transform the moral right into a legal right because in contemporary American society only a legal right will be effectively recognized and honored. Thus, one way to correct a rights violation is through the political and legislative process.

2. Part Two

Part Two of this dissertation addressed Policy, specifically efforts that have been attempted in the past century to transform this moral right to health care into a legal right to health care. With one exception, all attempts to date have failed. Part Two first examined the health care entitlements provided by several other nations. Virtually every

other developed industrialized nation guarantees access to health care to its people. Every other developed nation has created a system for insuring its entire population so that residents are legally entitled to coverage of their health care costs.³⁸⁵ Furthermore, universal health care has not bankrupted these nations. On the contrary, all other developed nations spend significantly less on health care than does the United States, in both the absolute terms of dollars per capita and the relative terms of percentage of gross domestic product. The standard of health in these other nations is at least equivalent to or better than the standard of health in the United States. Part Two then focused on what Americans have as yet failed to do by examining a subset of the many attempts to accomplish comprehensive health care reform in the past century. Now, nearly a decade into the twenty-first century, it has become increasingly unlikely, despite the recent (March 2010) enactment of health insurance reform legislation, that substantive reform of the American health care system through the political and legislative process will be accomplished unless the American people take action.

Since justice demands redress and since efforts to effect reform through the political and legislative process have not, in general, succeeded, then it is necessary to look for some other means of accomplishing reform. Thus, the thesis of this dissertation is that a social reform movement is called for in order to effect substantive reform of the American health care system. The American people will have to take action, as their forebears did in previous centuries, to redress the injustice of this rights violation.³⁸⁶

³⁸⁵ See Timothy Stoltzfus Jost, *Disentitlement? The Threats Facing Our Public Health-Care Programs and a Rights-Based Response* (New York, NY: Oxford University Press, 2003), p. 3.

³⁸⁶ American activism was apparent in the recent (March 2010) successful enactment of health insurance reform legislation. This legislation marks a significant step forward in health care reform but it is only the

When the government is unwilling or unable to redress injustice, then the citizens must act to accomplish reform. For millennia, revolution³⁸⁷ has been one means of effecting change. However, since the eighteenth century, social reform movements have become acceptable, even preferable, nonviolent means of accomplishing reform.

B. Overview of Part Three

The general thesis of this dissertation is that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because efforts to accomplish reform through the political and legislative processes have not succeeded. Part Three will support this thesis by focusing on Reform, specifically on how social reform movements accomplish reform and how a social movement for health care reform might begin and develop in contemporary American society. Part Three will develop in four chapters.

1. Chapter Five

Chapter Five will develop the thesis by providing necessary background information on social reform movements in general, what they are and how they accomplish reform. Although social reform movements usually begin when governments are unable or unwilling to take necessary action to redress injustice, the ultimate resolution of the injustice must be accomplished through government action. Chapter

beginning of the work that needs to be done. Thus, there is and will continue to be a need for American activism in order to accomplish substantive reform of the American health care system.

³⁸⁷ In the eighteenth century, the injustice of taxation without representation led the American colonists to revolution and a War of Independence from the mother country, Great Britain. Oppression of the French peasants led to the French Revolution. In the twentieth century, the Russian Revolution led to the overthrow of the Tsar and the triumph of Bolshevism, which quickly evolved into Communism. In the mid-twentieth century, both Hungary and Czechoslovakia revolted against the domination of the Soviet Union. (Poland, however, accomplished a measure of reform through the Solidarity movement.) To this day, revolution remains as an extreme form of social protest.

Five will argue that government must play a role in both accomplishing reform and the newly reformed social program.

2. Chapters Six and Seven

Chapters Six and Seven will develop the thesis by examining the work of the first two American social reform movements, abolition and woman's rights and suffrage, and extracting lessons that may be applied to a contemporary social movement for health care reform. Two social reform movements are examined because they developed somewhat differently and thus have unique as well as common lessons for contemporary social reform activists.

3. Chapter Eight

Chapter Eight will develop the thesis by clarifying the work to be done by American social reform activists in beginning and sustaining a health care reform movement and by addressing implications for related fields such as health care ethics. Chapter Eight will conclude with a brief recap of the major points of the dissertation and how each point helped to develop the thesis.

II. What is a Social Reform Movement?

A Social Reform Movement is a relatively new and innovative form of social protest that emerged in the late eighteenth and early nineteenth century and enabled ordinary people to make collective claims on authorities, public or private, and achieve objectives without resorting to the violence of a bloody revolution. The new form of social protest was a distinctive way of pursuing public politics that evolved into modern social movements with sustained, organized public campaigns, a repertoire of practices including special-purpose associations, rallies, vigils, and pamphleteering, and public

representations of worthiness, unity, numbers, and commitment on the part of themselves, their constituents, and their cause.³⁸⁸ Social movements, an invented and distinctive form of contentious politics, began in England³⁸⁹ and quickly migrated to Western Europe and the United States. Social movements are contentious because they involve the collective making of claims that, if realized, would conflict with the interests of other parties. Social movements are politics because governments almost always are involved, usually as the object of the claim.³⁹⁰ When authorities were unwilling or unable to act to redress injustice, people, ordinary citizens, began to form social movements to effect necessary reforms. In the United States, for example, a number of different social reform movements developed and helped to raise the consciousness of other ordinary people, first to become aware of injustice and then to take action to redress the injustice.³⁹¹

³⁸⁸ Charles Tilly refers to these public displays as “WUNC” (Worthiness, Unity, Numbers, Commitment). For more information on the history of social movements, the interaction of campaign, repertoire, and WUNC, and specifics on what constitutes WUNC, see Charles Tilly, *Social Movements, 1768-2004* (Boulder, CO: Paradigm Publishers, 2004), Chapter 1.

³⁸⁹ In England, some of the earliest examples of the contentious politics that underlie social movements date to 1768. In that year, coal handlers backed their demands for higher piece rates by blocking the sale and shipment of coal and silk weavers put pressure on wage-cutting masters and the journeymen who produced for them at the lower wage by cutting cloth from their looms. More significantly, in this time of narrow voting rights, nonvoters held disciplined mass demonstrations and took nonviolent action to support the election campaign of a candidate for parliament. This third example foreshadows what will become the social movement repertoire. See Tilly, *Social Movements*, Chapter 2, pp. 16-21.

³⁹⁰ Claims are usually made against authority that may or may not be the civil government. Thus, for example, in the labor union movement, workers made claims against employers whereas in woman’s suffrage, claims were against the government, state and federal.

³⁹¹ Great American social reform movements include the abolition of slavery, woman’s rights and suffrage, labor, senior citizens, and Civil Rights. Abolition will be presented in Chapter 6 and Woman’s Rights and Suffrage in Chapter 7. The labor movement sought to address the exploitation of workers that resulted from industrialization, gaining strength as workers organized to make collective demands on employers, using public meetings and demonstrations to make their plight known to the public. They eventually formed labor unions, entered into collective bargaining, and obtained higher wages for shorter hours in improved working conditions, plus additional benefits. In the early twentieth century the elderly organized for the purpose of gaining old-age pensions from the federal government and were instrumental in, but not

III. Characteristics of a Social Reform Movement

Social reform movements, in general, have a number of common traits. All involve ordinary people with access to neither resources nor power, who make collective demands for the redress of injustice. These movements occur in many situations against many odds and are frequently successful. Social reform movements are all bottom-up approaches to resolving injustice, starting with ordinary people and spreading in ever-widening circles to attract more ordinary people. As these movements spread wide, they also percolate up the social ladder to reach the elites, the influential, and the authorities. They always demand action. Eventually a successful social movement will attract a critical mass of ordinary people, making their demands potentially more acceptable in a democratic republic. Thus reform may be accomplished without violence.

However, while common traits are likely and even necessary for cohesion, they are not sufficient to delineate a social reform movement from other forms of social action. A social movement develops from and consists of a synthesis of three elements: a campaign, a repertoire of political action, and a continuing public display of worthiness, unity, numbers, and commitment (WUNC).³⁹²

directly involved with, the Social Security Act and associated legislation of the 1930s. Although dormant for more than two decades, senior citizen activism reemerged in the 1950s in the effort to enact Medicare legislation. Since then they have worked zealously to gain additional benefits and defeat any attempts to decrease existing benefits. In the mid-twentieth century, African-Americans organized to demand in fact the civil rights that had been granted to them in law after the Civil War and succeeded in desegregating the South and gaining at least some equality of access to jobs and other opportunities. Medicare was instrumental in desegregating Southern hospitals because federal monies would not be granted to any segregated institution.

³⁹² For further explication of social movements, see Tilly, *Social Movements*, Chapter 1; Sidney Tarrow, *Power in Movement: Social Movements and Contentious Politics*, 1993, Second Edition (Cambridge, MA: Cambridge University Press, 1998), Introduction and Chapter 1.

A. Campaign

A campaign is a sustained, organized public effort making collective claims on target authorities. It is sustained because it always extends beyond a single event and continues over some, usually long, period of time as distinguished from a single demonstration or a reaction to some occurrence. A campaign is an organized, deliberate effort, wherein associations of individuals directed by some force work toward a specific goal. This distinguishes a campaign from a random crowd or mob that happen to be or to come together at the same time. A campaign is a public effort, open, overt, accessible by all and addressed to all, purposeful work directed toward a goal. It makes collective claims on target authorities. The effort is directed toward a specific goal or set of goals and the entire group of activists is working for the same goal or goals. The target authorities are those who make policy, usually government but possibly other authorities such as employers or owners. The policy makers will eventually direct the changes to policy and laws that will accomplish the reform being demanded by the activists.

A campaign always includes at least three entities: the group making the claim, the object of the claim, and the public.³⁹³ The group making the claim are the activists, the group of individuals who perceive the injustice and agitate for social reform. The object of the claim are those who are committing and/or condoning the injustice and who will have to make the necessary adjustments to policy and law in order to effect the social reform and redress the injustice. Everyone who is not an activist working toward social

³⁹³ For example, in the Woman's Rights and Suffrage movement, the women activists were the claimants, multiple levels of government – local, state and federal – were the objects of the claim, and the public involved those who did not understand the issues involved. The claim, of course, was that women were unjustly deprived of civil, legal, and property rights including the political right to vote.

reform is a member of the public and activists must convince them of the necessity of reform. Once converted to the cause of reform, the public will join the activists and help to generate the public turbulence that will eventually cause policy makers to respond and make the necessary changes in policy and law. The interaction among these three entities — the group making the claim, the target authorities, and the public — constitutes a social movement.

B. Repertoire

The social movement repertoire consists of a number of forms of political action, all intended to get the message of social reform out to the public and to persuade the targets of the claim to take action to resolve the issue. Repertoire activities are political action because they are designed to get the attention of the policy makers who will ultimately make the necessary changes to policy and law. One form of political action is to create special purpose associations or coalitions because the collective voice of a group has more impact than a solitary individual speaking alone. An association or organization lends weight to the claim. Demonstrations, rallies, and public meetings are other forms of political action as are speeches, lectures, and education campaigns. Pamphlets and tracts have been part of the political action repertoire for centuries and in contemporary times have been augmented with websites and information hotlines. Petition drives, letter-writing campaigns, and boycotts are time-honored entries in the political action repertoire. Processions, marches, and vigils are also popular forms of political action. The objective of political action events is to deliver the message that will convince people of the need for social reform and, in the process, to stir up public opinion. Stirred-up public opinion will generate turbulence among the uninformed, the

passive, the apathetic, the opinion makers, the elite, and especially the opposition.

Turbulence will cause elites in particular to make demands on policy makers. Policy makers will eventually respond to the demands of the elites, although they will not necessarily respond to the demands of the social reform activists.³⁹⁴ The integration of some or all of these activities into a sustained campaign is integral to a social movement and differentiates it from other varieties of politics.

C. WUNC

Continuing public displays of worthiness, unity, numbers, and commitment are designed to draw public attention to the cause, to the oppressed on whose behalf the cause is being agitated, and to the activists who are pursuing the redress of injustice. Displays of worthiness, unity, numbers, and commitment can be in the form of statements, slogans, labels, or other idioms that a local audience can recognize and relate to.

1. Worthiness

A display of worthiness is meant to demonstrate to the public that both the cause and those on whose behalf the cause is being agitated have value and are worthy of support. Activists show that they, and by extension the cause they are agitating, are worthy of respect by being neatly dressed and by exhibiting a sober demeanor. Another indication of the worthiness of the cause is that respected members of the community, such as clergy, business and civic leaders, and other dignitaries, participate in the public

³⁹⁴ It is significant that policy makers will respond to the demands of the elites but not necessarily to those of social reform activists. Thus, one of the aims of a social reform movement will be to disrupt the comfort zone of the elites so much that they demand action. If policy makers responded to the demands of social reform activists, then demonstrations or petitions would be sufficient to accomplish reform.

displays. When mothers bring their children, or the elderly or the disabled participate, these are other indications of the worthiness of the cause.³⁹⁵

2. Unity

Displays of unity include anything that helps to identify participants as a group, rather than a random collection of individuals. Visible insignia, such as matching hats, caps, badges, headbands, or shirts, help to identify participants as members of a specific group.³⁹⁶ Marching in ranks, carrying banners, and singing or chanting while participating in the demonstration are other means of indicating unity.

3. Numbers

Organizations usually keep track of membership to measure growth. Displaying these numbers is a means of advertising the growth of the cause and enticing more people to join the movement. Counting and announcing the number of attendants at a particular event³⁹⁷ is one way of making the public aware of the level of support for the cause. Filling a public area known to hold a large number of people — such as the Capitol Mall in Washington, D.C., Times Square in Manhattan, or Pershing Square in Los Angeles — is a very public way to make the public and the media aware of the level of support for

³⁹⁵ Consider recent (April-May 2007) demonstrations by immigrants as an example of worthiness. Whole families participated, from the tiniest baby in its mother's arms, to toddlers, school children, young adults, and all the way through grandparents and beyond. The crowds were orderly and well behaved. Clergy were in attendance as were civic leaders and legislators.

³⁹⁶ Consider the era of the Vietnam War and the antiwar protests. Although not actually a social movement, unity with the group could be seen in the counter-culture clothing, the long hair and beards, the love beads and the peace symbol. During the Civil Rights movement, activists sang "We Shall Overcome" to signify unity.

³⁹⁷ In the world of sports this has been done for many years. The attendance is always announced and displayed on the scoreboard.

the cause. Counting the number of accesses to a website or the number of calls to a hotline are still other methods of measuring support.

4. Commitment

Displays of commitment are anything that demonstrate the depth of the activists' support for the cause and their willingness to work in spite of adverse circumstances. Demonstrating and working for the cause in bad weather, such as rain, snow, or sleet, is one way of demonstrating commitment. Continuing to advocate the cause in spite of repression or even violent opposition is another way of displaying commitment. Any activity that indicates the cause is so important that activists are willing to go to great lengths to support it³⁹⁸ and convince others to join the movement is a means of displaying commitment.

The integration of these three elements (campaign, repertoire, WUNC) and sustainable collective action separate a social movement from other forms of contentious action. Social movements must be able to maintain their challenge of the status quo in the face of formidable opposition and it is this ability to interact with powerful opponents while maintaining identity and sustaining collective action that is the mark of a social movement.

D. Nature of a Social Movement

A social movement will by its very nature and activities stir up public opinion and cause unrest and turbulence among the uninformed, the apathetic, the passive, the opinion

³⁹⁸ Consider the Civil Rights movement, the Freedom Riders in particular. They were attacked with dogs, fire hoses, and batons but they did not give up. Consider the beginning of the Woman's Rights and Suffrage movement, when some women walked as many as fifty miles or more just to attend the first meeting.

groups, the elites, and especially the opposition. Policy makers, usually the target of the social reform movement, may not respond to the claims of the movement but will in the end respond to the degree of turbulence generated and the consequent demands made by the elites and the opinion groups. Actions that begin in the streets are, and must be, resolved in the halls of government.

It is important to bear in mind that the opponents of any type of social reform almost certainly are and will be powerful and very well organized, with access to almost unlimited funding. Further, it must be understood that any social movement must be able to sustain collective action in interacting with these powerful opponents while utilizing various forms of political action and making public displays of worthiness, unity, numbers, and commitment. With these factors in mind, what resources would a social reform movement need, not only to begin the work, but also to sustain the effort in the face of vigorous opposition? How would a social reform movement begin, attract adherents, define the issue, formulate a message and get the message out to the voting public? What symbols, what methods of communication, and what message would a contemporary social reform movement utilize?

IV. Structure of a Social Reform Movement

A social reform movement is not unlike a political campaign or a marketing effort. However, whereas a political campaign sells a candidate and a salesman sells a product, a social reform movement sells an idea. A social reform movement, therefore, would require some of the same structural elements as a political campaign or a massive marketing effort, such as leadership, organization, access to and dissemination of

accurate and readily available data and information, and the ability to react quickly to changing circumstances.

A. Leadership

Leadership³⁹⁹ is essential and leaders emerge at the grassroots level. These leaders are the first to take action, to begin the work of focusing a vague notion of public support for the cause into a force for political action. The history of earlier social movements, notably Abolition and Woman's Rights and Suffrage, indicates that leadership is very important. In the nineteenth century, although some citizens and even a few civic and political leaders privately denounced slavery, and although many women were openly dissatisfied with their inferior social status, nothing was done to resolve either issue until leaders, William Lloyd Garrison and Elizabeth Cady Stanton, emerged and took action. Any social reform movement will need dynamic and dedicated leaders to bring the issue into the public domain and stir up public opinion enough to cause turbulence among the uninformed, the apathetic, the passive, the opinion groups, the elites, and especially the opposition. When enough turbulence has been stirred up, policy makers will begin to respond, although not to the claims of the social movement but rather to the demands of the elites, the opinion makers, and the opponents of reform.

Social movements are always bottom-up, with action beginning at the grassroots level. It is at this local, grassroots level that leaders will emerge and these local leaders

³⁹⁹ Placing leadership at the head of the list of structural elements that delineate a social reform movement does not imply that the work cannot begin until leaders emerge. The work at the grassroots level will almost certainly have begun as leaders emerge and in fact the individuals who actually begin the work of reform will probably be the first leaders. However, the emergence of leadership marks the beginning of the transition from local, inchoate, unfocused work on reform to the focused effort that could become a full-blown social reform movement. Thus, leadership is essential to the social reform movement but lack of defined leadership should not impede the work of reform.

will be indispensable to the growth and success of the social reform movement. People at the grassroots level are and will be the heart of any social reform movement and local leaders know these people, live in the same communities, attend the same churches and civic functions, socialize with them, and understand the challenges and hardships that they face every day. Thus, local leaders know how to talk to the people at the grassroots level in terms they will understand and what to emphasize in order to attract people who are interested in but not yet fully committed to the cause of reform. Local leaders also know the business men and women in the community, the local clergy, and civic leaders, whose support will be crucial in moving forward with any social reform movement.

As the social reform movement begins to grow and gather steam, a hierarchy of leadership will also begin to develop. Local leaders will emerge first and will continue to be indispensable throughout the life of the movement, but other leaders, at state and national levels will also ultimately be necessary.

Leadership at the state level is critical to success. This second level of leadership will direct and coordinate the efforts of the various grassroots campaigns so that each state will speak with one voice on the need for reform and provide a bloc of support for the movement. State leaders will devise strategy for the state level of activity and implement the national strategy. In addition, the state leaders will need access to politicians, political advisors, economic advisors, and a host of other leaders at the state level. Ideally, state level leaders will also have access to and work with Congressional Representatives and Senators and their staffs.⁴⁰⁰

⁴⁰⁰ The whole idea of a social reform movement begins to sound impossible as soon as the discussion moves beyond the passion of the issue to the practical details of such things as levels of leadership, strategies, tactics, financing, etc. However, the magnitude of the task of effecting social reform cannot be

Leadership at the national level will be the most visible and these leaders will have the responsibility of mapping the strategy and tactics for the entire social reform movement. Although it is not absolutely necessary, it would be beneficial if at least some of the national leaders were charismatic personalities. A charismatic leader will draw attention, from the media as well as from the people at the grassroots level, and this can help to advance the cause. A charismatic leader can act as both spokes person and lightning rod. As spokes person, a charismatic leader can relieve others of the burden of delivering the right messages at the right time, and as lightning rod, a charismatic leader can deflect the attacks and criticism of the opposition. It is absolutely imperative that national leaders of a social reform movement cultivate political insiders who can introduce bills and who have the necessary experience to attach potentially costly reform initiatives to other less visible budget measures.⁴⁰¹ Political insiders would include influential congressional committee chairs and the civil servants who support them as well as supporters for the cause of social reform. National leaders must be able to tap into the expertise of Washington insiders, think tanks, policy institutes, universities, and others who support social reform, understand the process by which issues that have public support get onto the national policy agenda, and know how to draft legislation and get it enacted. National leaders will also need economic advisors, publicity campaign experts, and a staff with superb administrative skills.

forgotten or minimized. Consider, for example, reform that could possibly only be accomplished through Constitutional amendment. That would mean that 38 states would have to agree, that is, to ratify, the proposed amendment. This would not likely happen without a well-organized structured campaign, a hierarchy of leadership and all the other necessary ingredients of a complex battle plan.

⁴⁰¹ See Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (New York, NY: Oxford University Press, 2005), pp. 212-13.

B. Organization

The structure of the social reform movement organization will be closely allied to leadership and should emulate and reflect the organizational structure of the coalition of stakeholders that opposes comprehensive social reform. Opponents of reform almost always have national leadership, state level organizations, and local networks capable of marshaling grassroots support. Past social movements, the few but notable instances when ordinary citizens defeated elite stakeholders, had strong organizations comparable to the federated structure of American government. This type of organizational structure clearly works so it will be necessary for any social reform movement to develop such a three-tiered coalition of local, state, and national support. The leadership discussed earlier must incorporate the strength of the three-tiered organizational structure.⁴⁰² The three-tiered organization can attract adherents at every level and past experience demonstrates that support will be needed at every level. Strong leadership in conjunction with organizational strength can develop and execute a campaign plan that will utilize the talents and energy of every person involved in and committed to social reform. Any well-run organization tends to look successful and this aura tends to attract more adherents from all walks of life and thereby broaden the base of support for reform.

1. National Level

The national level of the social reform movement organization will have the responsibility of mapping out the grand plan for the overall campaign, and developing

⁴⁰² The value of the organizational structure was demonstrated very clearly in the last five years of the battle to achieve suffrage for women. Carrie Chapman Catt had both the administrative talent to create a multi-layer structure and the political acumen to exploit it. See Chapter 7 for further discussion of Woman's Rights and Suffrage.

strategy and tactics. Finances will be controlled at the national level and ideas from all levels will be evaluated and, if appropriate, incorporated into the campaign plan. The national level will have the staff with the contacts and expertise to gain support from a wide variety of people, including those who are policy elites. The national organization should prepare training guides for use at state and local levels as well as briefing books for key members of Congress. The national organization must also be cognizant of the opposition at all times and be prepared to counter any negative statements, ad campaigns, and potentially insidious misrepresentations of the facts and aims of the social reform movement. Just as coalitions of ordinary citizens⁴⁰³ set the terms of the debate in previous attempts at social reform, so too the national organization of any contemporary social reform movement must seize the initiative from the powerful coalition of antireform stakeholders and set the terms of the debate over succeeding attempts at comprehensive social reform.

2. State Level

The middle or state level of the social reform movement organization must cultivate and involve intermediate levels of other organizations such as state labor federations or senior citizens' clubs whose leaders can then help to spread the message of reform by coordinating activities, tapping into indigenous social networks, and disseminating the reform movement's ideas and literature. Additional work at this intermediate level would include recruiting organizations of other concerned citizens who feel change is needed but are not sure what to do about it and persuade them to become

⁴⁰³ During the campaign to enact Medicare, for example, coalitions of senior citizens set the terms of the debate, wresting control away from coalitions of health care providers.

committed to the cause of social reform. It would be particularly beneficial to recruit supporters of reform who live in the districts of key members of Congress and ensure that these supporters regularly write their congressional representatives and press for social reform legislation.

3. Local Level

The local chapters of the three-tiered social reform movement organization will mobilize grassroots activists to engage in social and political action. Much of the political action repertoire discussed earlier will be determined and accomplished by the local chapters. Some timetables may be set by the state or national organization but the details will be accomplished at the local level where the leaders know the territory and the people. Local demonstrations, petition drives, and letter-writing campaigns will be conducted at the local level, as will fund raising events. The local chapters will be responsible for raising the funds needed to keep the movement alive and passing those funds to higher levels in the organization. It is highly unlikely, however, that the movement will have anywhere near the funds available to the coalition of antireform stakeholders. Most probably the social reform movement will have to accomplish with numbers of adherents and the vote of each what the opposition will work to defeat with political influence and nearly unlimited funding. However, this has been true in the past yet previous social reform movements succeeded in effecting comprehensive social reform. The abolitionists, for example, had almost no funds and yet prevailed against the formidable opposition of slaveholders who had wealth, political power, and

Constitutional protection for the institution of slavery. Similarly, the activists fighting for woman's rights and suffrage had little funding yet achieved their goals.⁴⁰⁴

C. The Issue

Part of the function of leadership is to formulate and hone the issue the social reform movement will be agitating. This element is difficult to conceive and harder still to accomplish. If the issue is defined ambiguously, it will be easier to attract a wide variety of adherents to the cause. Everyone will find something to agree and identify with. This is not unlike the thin concept of justice presented in Part One of this dissertation. The ambiguity also permits definition at a very broad level so that the details of implementation do not cloud the big picture of the issue. The broader and more ambiguous the issue, the more likely it will appeal to the decision makers as a matter of compelling importance and one that is worthy of their serious concern. It must be remembered that any social reform issue will never move beyond grassroots support to political enactment without the support of the policy brokers and decision makers. Therefore it would be in the best interests of success to be cryptic and enigmatic in defining what the social reform movement aims to accomplish.

On the other hand, at some level, the issue must be precisely defined, if for no other reason than that it provides a measurement for success.⁴⁰⁵ Perhaps this precise

⁴⁰⁴ Women had no legal right to own property or to keep their own wages for many years of the movement's work. Thus, the group most concerned with achieving rights and suffrage could not contribute much in the way of direct financial support. The women contributed in many other ways, however.

⁴⁰⁵ This paradox of simultaneous ambiguity and precision may become clearer in the discussion of abolition (Chapter 6). Briefly, the message that was preached by the abolitionists was precise: emancipate all the slaves immediately and grant them full and equal rights. The message that was heard and spread was more ambiguous, i.e., a message of anti-slavery that came to mean many things including opposition to the spread of slavery. Those who opposed the spread of slavery were not necessarily willing to support immediate emancipation with full and equal rights. Nevertheless, the opponents of the spread of slavery

definition has to be kept confidential within the ranks of the leaders of the movement, at least for a time. There is precedent for confidentiality within other social reform movements. In the last years of the Woman's Rights and Suffrage movement, Carrie Chapman Catt, for example, entered into a secret compact with more than thirty-six state suffrage organizations and entrusted them with the extremely detailed plans of the campaign that would finally win suffrage for American women.

Thus, it is important that the issue be defined ambiguously for potential adherents and ultimate decision makers, but it is equally important to have a precise definition of the issue for those who will be creating the repertoire, running the campaign, and orchestrating public displays of worthiness, unity, numbers, and commitment.

D. The Message

The message is more than the issue. The message is how the issue is presented to current and future supporters and includes, for example, persuasive points on why this issue is important, in general and specifically to each individual, and how this campaign differs from previous attempts to enact comprehensive social reform legislation. The message must also counter opposition propaganda, probably by suggestion more than by direct counterattack.

An organized coalition of antireform stakeholders will most probably raise arguments for the specific reason of creating fear among undecided but potential supporters of reform. The contemporary movement must be prepared to take the message in another direction, to frame the issue and therefore the debate in their own terms. A

still supported the anti-slavery message and this provided impetus for policy makers to take action to end slavery.

reasoned argument as a direct rebuttal to opposition fear tactics would most likely fail because a reasoned argument addresses the intellect whereas fear resides in the emotions. Thus, the contemporary social reform movement must be prepared to take the public in a different direction, where the movement controls the message. A clever message from the social movement can frame the debate in their terms, just as the senior citizens seized the initiative away from the organized opposition to reform during the Medicare debate.

The message will have to be carefully crafted so that the social reform movement controls the debate. Further, the message will have to be refined so that it speaks to each audience in terms the particular audience can understand and relate to. The message also must be fundamentally true. Americans are capable of reforming any unjust social system and they can do so if only they will. The message of the social reform movement can aid in shaping and strengthening the national will so that the proposed reform will become enacted reality.

E. Identity

Identity refers to those on whose behalf the movement is conducting its campaigns of collective action. Thus, the abolitionist movement worked on behalf of the slaves who could not agitate on their own behalf. The woman's rights and suffrage movement was waged on behalf of all women, some of whom did not actively participate in the campaigns of collective action but who benefited nevertheless.

In a contemporary social reform movement, the identity of those on whose behalf the movement is conducting its campaigns of collective action would depend on the cause being agitated. A related question is whether there is some unique way to identify those on whose behalf the movement is working. This question of identity was not an

issue in previous social movements. The abolitionists identified slaves by the color of their skin because all slaves were black, though not all blacks were slaves. The beneficiaries of the Woman's Rights and Suffrage movement were recognized by their sex or gender. More recently in the social movement that accompanied the enactment of the Medicare legislation, the beneficiaries were senior citizens and thus identified by their age. A contemporary social movement would have to discover or create some identifying characteristic that would link the beneficiaries together.

F. Symbols

Symbols are closely related to identity and can be powerful reminders of a cause. Consider, for example, the peace symbol. It is highly recognizable and immediately identified with the cause of peace, yet it does not have any apparent connection to the cause. The yellow ribbon indicates support for the troops, the red ribbon indicates support for AIDS patients, and the pink ribbon indicates support for breast cancer research.⁴⁰⁶ Yet none of these has any overt connection to the cause it symbolizes. They are all highly abstract and ambiguous. The symbols are meaningful because people invest them with meaning.

For many years the March of Dimes would select a poster child to be the visible image of the campaign against polio. The poster child would thus personify and make concrete the abstraction of the fight to eradicate polio.

⁴⁰⁶ Beyond merely the pink ribbon, the color pink has come to indicate support for breast cancer research. Manufacturers (for example, Campbell's Soup and Mars Candy) produce pink labels or wrappers for their products or actually color their product pink (M&M's, Tic Tacs) to indicate special support for breast cancer research.

Nations use symbols, religions use symbols, professions use symbols, and corporations use symbols. Each symbol evokes in some way the meaning of that which is symbolized. Symbols indicate military rank and thus both identify the person as a member of the armed forces and at the same time provide information in regard to the wearer's rank within the hierarchy of the organization.

Symbols can be concrete as well as abstract. The abolitionists used images of slaves, in chains or on the auction block, and these symbols were powerful reminders of the aims of the movement, and for whom it was working. Garrison used "a picture of a slave auction situated in front of the nations Capitol with liberty's flag atop its dome and a whipping post in its plaza"⁴⁰⁷ on the masthead of *The Liberator* to emphasize the terrible contradiction between slavery and a nation conceived in liberty for all, to evoke individual sympathy, and to appeal to collective identity.

A contemporary social reform movement will also need at least one symbol. The specific symbol will depend on the cause being agitated, but it should make the abstract idea of justice into a concrete living reality. That is, the symbol should remind everyone that the social reform movement is being agitated on behalf of real people who are suffering because of the injustice that the cause seeks to remedy. It may be possible to draw on human experience to find stories⁴⁰⁸ that could characterize the contemporary

⁴⁰⁷ Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery* (New York, NY: St. Martin's Press, 1998), p. 124.

⁴⁰⁸The Biblical story of David and Goliath might be adapted as a symbol of the powerlessness of ordinary citizens against the might and strength of organized opposition. The folklore story of Jack the Giant Killer could be adapted for the same reason. The mythological Gordian Knot could symbolize both the complexity of the problem to be resolved and the boldness that will be required to resolve it. An iceberg could symbolize both the size of the problem and the hidden power of the opposition.

problem and act as a springboard toward developing a symbol that dramatizes the message of the contemporary social reform movement.

It is highly likely that a symbol or symbols will develop spontaneously at, for example, the local grassroots level of agitation and one or more may evolve into or be adapted to become a national symbol of a contemporary social reform movement. Ideally, the symbol will put a face on the issue being agitated. Most people relate more easily to other persons than they do to either ideas or facts. Thus, for example, people immediately identify the Civil Rights movement when they see pictures of Rosa Parks or Martin Luther King, Jr. Symbols will be necessary and should be exploited whether they develop spontaneously, are adapted from symbols used in previous successful social movements, or are created specifically for a contemporary social reform movement.

G. Communications

Effective communications methods will be essential for any contemporary social reform movement in order to spread the positive message of reform to supporters and potential supporters, to counter the negative messages of the opposition, to attract media attention, and for other purposes as well. Movement leaders will also have to be able to communicate with each other, top-down, bottom-up, and peer-to-peer.

The Internet and electronic mail are very popular methods of communication, especially among the young and upwardly mobile and should definitely be employed but should not be the only or even the primary methods of communication. Many of the citizens whose support will be critical to the success of the social reform movement may not have access to the Internet or to electronic mail. Printed communications may be the best way to address a large number of people of varying education, social status, and

access to technology. The printed word has been around for millennia whereas the Internet is a comparatively recent development. However, a dual approach of sending printed matter and simultaneously posting the information to movement websites could be very effective.

A newspaper or circular should be considered as a vehicle for agitating the social reform movement message in the movement's terms, not colored by the bias of any other reporting medium. It would be one place where the reform message would be neither diluted nor misrepresented, and could be presented in its entirety rather than being quoted out of context. Past social movements have published newspapers for just that reason. William Lloyd Garrison founded *The Liberator* specifically to agitate the message of the abolitionist movement and focused on that message until the Thirteenth Amendment was ratified. The Woman's Rights and Suffrage movement relied on the abolitionist newspapers until they finally got a newspaper of their own, *The Revolution*, in 1868. Although other forms of communication may be more convenient, the printed word will be more thoughtful, conceivably more accurate, and almost certainly more durable.

Whatever forms of communications are employed and however many types of communications are used, the intent should be to give all supporters and potential supporters equal access to the information. The activists who will probably emerge as social reform movement leaders may have access to a higher level of technology and have more technical expertise than rank-and-file members, but it is the grassroots support that will make the movement successful and it is to their level that communications should be tailored.

Accurate and timely information presented in an interesting manner using all important communications techniques will help to build sufficient public support for the cause of reform to convince decision makers that the issue ought to be part of the national policy agenda. A communications director will be as important to a contemporary social reform movement as such an individual is to any political campaign or to the White House.

V. Initiating a Social Reform Movement

A. The Work Begins, Grows, and Takes Shape

Before any social reform movement can orchestrate a campaign, develop a repertoire of political action activities, and organize public displays of worthiness, unity, numbers, and commitment, it must first begin. So it is appropriate to ask how any contemporary social reform movement might get started. A true social reform movement will always come from the action of the people at the grassroots level, people who realize that a specific injustice exists and must be rectified. One individual will move beyond merely talking about the need for reform and do something about it. Initial action may be something as simple as talking with friends, neighbors, and co-workers to build a nucleus of support for the need for reform. Initial action could also be something as dramatic as that of William Lloyd Garrison, who started his own newspaper, *The Liberator*, to agitate support for his cause of abolition or that of Elizabeth Cady Stanton, who called a public meeting to protest the status of women and to solicit discussion from other women. A local organization begins from the actions of a single individual at the grassroots level and grows from there. As the local organization begins to form, it will be important to let other like-minded individuals know that such an organization exists and to solicit

additional membership. Garrison did this by printing his newspaper and distributing it free of charge, to inform the public that the abolition movement was taking shape. The women of Seneca Falls announced their public protest meeting in the local newspaper and invited supporters to join the discussion. Whatever technique is used, support will begin to build and other local societies will take shape. Once the work has begun on a local level, it will be important for local organizations to communicate with one another, to share ideas and resources, and to begin developing a political action repertoire and organizing public activities to gain additional grassroots support. The next logical step would be to link the network of local societies to regional organizations and then link regional organizations to a national group. The resulting organization may be very formally structured or very casual, but the impetus will come from an individual at the local level who takes action and thus emerges as leader.

Having begun with a few dedicated individuals at the local level, a social reform movement will grow outward in ever-widening circles, as other individuals become interested in the cause of reform and join the movement. As local groups expand, and more local groups form and grow, a structured organization will begin to emerge. The movement will expand upward as well as outward and in the process attract attention above the grassroots level.

B. A Seminal Event

It is possible that some seminal event could occur that would act as a catalyst for a social movement and a focal point for the then-existing organizations. Consider, for example, the seminal event that occurred in Montgomery, Alabama in December 1955 when a black woman named Rosa Parks refused to give up her seat on a bus. It was a

simple act in itself but one that required great courage in that place at that time. This simple act led to a year-long bus boycott by the black community in Montgomery, catapulted a young black minister named Martin Luther King, Jr. into national prominence, and was the seminal event that united black citizens in the Civil Rights movement that eventually ended segregation in the South.

Consider also Cesar Chavez, a migrant farm worker who became a labor leader and sparked a reform movement. He called national attention to the plight of the migrant workers — the harsh and dangerous working conditions, the backbreaking work of picking, the low wages, the lack of security, and the deplorable living conditions — by organizing the four-year boycott of table grapes, the most successful boycott in American history. The boycott was a form of political action but it was also a seminal event that got the attention of the American public and united the migrant workers behind the leadership of Chavez who organized them into the United Farm Workers.

If some comparable seminal event were to occur in connection with a contemporary reform issue, it could unite activists into fostering a social reform movement. Such a seminal event, in addition to being a catalyst for action, could begin attracting public attention to the cause and raising public awareness of the need for reform. A seminal event would be beneficial but is not absolutely necessary in launching a contemporary social reform movement.

VI. Conclusion

A social reform movement is a means of accomplishing social reform and effecting comprehensive social change without resorting to the violence of revolution. When injustice and the consequent need for reform are recognized at the grassroots level,

and government cannot or will not take action to redress the injustice, ordinary citizens can take action through a social reform movement and bring the injustice and need for reform into focus for policy makers.

When the need for reform is recognized at the grassroots level, activists begin to take action to stir up public opinion and thereby raise the consciousness of their fellow citizens. As more ordinary citizens recognize the need for reform, they also begin to take action and this further stirs up public opinion. Eventually, even the uninformed, the apathetic, and the passive get drawn into the discussion, come to understand the need for reform, and provide some measure of support for the cause that the activists are agitating.

Activated public opinion will create turbulence at higher levels of the social hierarchy. The opinion groups will evaluate the stirred-up public opinion and the elites will complain about the disruptive influence of the activists and demand that something be done to control them. The opponents of reform will demand support for the status quo.

As the turbulence escalates, policy makers will respond, although most likely not to the claims of the social reform movement activists. Rather, policy makers will respond to the degree of turbulence and the consequent demands of the opinion makers, the elites, and the opponents of reform. Thus, ordinary citizens can begin the work of reform and focus the attention of policy makers on the need for reform by stirring up public opinion enough to cause the social disruption that will ultimately evoke response from policy makers.

In this way, the agitation that begins with the work of ordinary citizens at the grassroots level will ultimately be resolved in the halls of government. The government

will and must play a role in both accomplishing social reform and also in regulating and enforcing the newly reformed social program. The policy and legislation to provide legal support to redress a rights violation cannot be initiated and accomplished without the active support of the government.

A. Legitimate Role of Government in Social Welfare Programs

However, it is not enough for the government merely to take the initial action. Rather, the government must remain actively involved in formulating regulations to implement the law and in overseeing and enforcing the law. It must be noted and emphasized that government involvement in social welfare systems does not mean government takeover of those systems. Social welfare systems usually affect the entire citizenry and only the federal government has the experience and the global authority to oversee and regulate these systems. Social welfare, for example health care reform, is a national problem and must be addressed at a national level.

Government not only has the right to be involved in social programs but also has the obligation to ensure the social security of all Americans. Just as government must provide for the common defense, so too must it protect and promote the general welfare of the population. If the government has the authority and responsibility of maintaining armed forces to provide for the common defense, then, by analogy, it should have comparable authority and responsibility for creating and maintaining the social welfare systems that protect and promote the general welfare of the population.

The government already takes an active role in social welfare programs such as Social Security and Medicare/Medicaid. It should be noted that the federal government is also actively involved in providing aid to the unemployed at this time (2009-2010) of

rampant and escalating unemployment by extending federal extensions of unemployment compensation benefits to the unemployed who have used all the benefits they might get from other sources.⁴⁰⁹ Thus, for the general welfare of the American people, the federal government must continue to play an active, legitimate role in social welfare programs.

B. Emergence and Growth of Social Reform Movements

Social reform movements emerged in the eighteenth century as an alternative to violent revolution for accomplishing comprehensive reform of social institutions. In the years since social reform movements arose as an invented and distinctive form of contentious politics, several such movements have succeeded in accomplishing social change. In nineteenth century America, slavery, an institution that had existed certainly since the dawn of history and most probably as long as humans had banded together in societies, was abolished in large measure because of the actions of a few determined individuals. Likewise, in a movement that was born in and grew out of the abolition movement, women began to demand the same rights that men took for granted, including the right to own property and the right to vote.

More recently, the Civil Rights movement gained in fact the rights that had been granted in law when the Thirteenth, Fourteenth, and Fifteenth Amendments were added to the federal Constitution. Senior citizens have been very active in addressing and

⁴⁰⁹ Considering the number of objections raised about government involvement in health care, it must be pointed out that there is little or no objection from those who are reaping the benefits of the federal extensions to unemployment compensation. It is probable that there will be little or no objection from the beneficiaries of a reformed health care system when that reformed system is finally established and operational.

protecting the rights of the elderly. And labor movements continue to be active on behalf of workers.⁴¹⁰

Considering the success of past social reform movements, there is nothing to suggest that a contemporary movement would not or could not be equally successful. The key, of course, is to gather the support at the grassroots level and create enough of a groundswell to cause the policy makers first to take notice and then to take action. It should not be necessary to convert all citizens to the cause of reform, but it will be necessary to build a critical mass of support.

It should be emphasized, however, that activism at the grassroots level is only the beginning of the process to effect comprehensive social reform. The fight to redress injustice will of necessity move from social activism to political action. Whenever, wherever, however a contemporary social reform movement may begin, whether for the comprehensive reform of the American health care system or for some other injustice that must be redressed, the agitation that begins in the streets at the grassroots level will ultimately be resolved in the halls of government. The redress of injustice must be accomplished through the political process. Moral rights must be transformed into legal rights and this can only be done through the political and legislative process.

If a contemporary social reform movement were to arise and be successful in effecting reform of an unjust social system, such as, for example, the American health

⁴¹⁰ As I write this (December 2007), the Writers Guild of America is on strike to protect their right to profit from their work. Specifically, they are demanding residual payment when their work is sold on DVD or through the Internet. In reading the newspapers and listening to the news, I recognize some of the same thoughts that I have read in my research on previous social movements. Garrison always maintained that the tenacity of the slaveholders was an indication of just how lucrative slavery was for them. One of the writers commented that the tenacity of the producers in keeping the writers from profiting from DVD and Internet sales is a real indication of just how lucrative that market is.

care system, then it would be appropriate to learn as much as possible from the success of previous social reform movements. Thus, the next two chapters will examine predecessor movements. Chapter Six will examine abolition as a paradigm of a successful social reform movement and Chapter Seven will similarly examine woman's rights and suffrage. Chapter Eight will then consider how a contemporary movement to effect comprehensive reform of the American health care system might begin and progress, incorporating lessons and ideas from Chapters Six and Seven and also from the success of the organized coalition of opponents of reform that has heretofore blocked comprehensive reform of the American health care system.

Chapter Six

Abolition as a Social Reform Movement

I. Introduction

The thesis of this dissertation is that a social reform movement is called for in order to effect comprehensive reform of the American health care system. If it is appropriate to build such a movement now in the twenty-first century, then it is also appropriate to learn from successful social reform movements of past centuries. The first American social reform movement was the successful movement to abolish chattel slavery in the nineteenth century. This social movement began shortly after social reform movements emerged as an invented and distinctive form of contentious politics and quickly evolved into the preferred alternative to violent revolution as a means of effecting comprehensive social change. The American abolition movement, in less than half a century, succeeded in dismantling the social system of chattel slavery that had existed for all of recorded history, a system that had evolved into racial slavery and existed in the Americas since the time of the earliest settlers in the sixteenth century.

II. What is Abolition?

Abolition refers to the act of destroying completely. As a social movement, abolition was the sustained, organized campaign to remove wholly and completely the institution of racial chattel slavery as an American social and economic system. The

system of plantation slavery was highly productive and anticipated much of the efficiency, organization, and global interconnectedness of industrial capitalism. Yet, in less than a century slavery ceased to exist in the New World in spite of being both highly profitable and also productive.

Why was there, in the nineteenth century, a movement to abolish slavery, an institution that had existed for millennia?⁴¹¹ The abolition of slavery in the New World came about because of a moral transformation, unprecedented in recorded history, characterized by “the emergence of a widespread conviction that New World slavery was deeply evil and embodied all the forces that threatened the true identity of the human race.”⁴¹²

III. American Abolition

A. A Movement Begins

The young men and women who began to focus on the abolition of slavery in the 1830s considered racial slavery to be “*the* great national sin,”⁴¹³ and began to work to eradicate the institution in the United States. These young men and women recognized

⁴¹¹ Various forms of slavery arose in the ancient Near East, Africa, Asia, and the Americas long before “they were systematized by laws and legal codes” such as the Code of Hammurabi in the late 1600s B.C.E. Documents from Sumer, the oldest extant, reveal that slavery existed in 2000 B.C.E. Among the ancient Greeks, Plato, Aristotle, and Xenophon all spoke of slavery, and slave labor was central to the economy and way of life of Ancient Greece. Slavery was recognized under Roman law although the fifth-century Code of Justinian ruled “that slavery was the single institution contrary to the law of nature [that was] sanctioned by the law of nations.” Augustine and the other church fathers drew a connection between society’s need for slavery and the universal depravity that was the result of original sin. In the Hebrew Bible, it is clear that Abraham and many of the prophets owned slaves. In the New Testament, Jesus never criticizes the slaveholding that surrounds him or speaks to a slave. Slavery was universally accepted throughout history. See David Brion Davis, *Inhuman Bondage: The Rise and Fall of Slavery in the New World* (New York, NY: Oxford University Press, 2006), p. 32 and p.35.

⁴¹² David Brion Davis, *In the Image of God: Religion, Moral Values, and Our Heritage of Slavery* (New Haven, CT: Yale University Press, 2001), p. 131.

⁴¹³ Davis, *Inhuman Bondage*, p. 252.

injustice and acted to end it. In this effort, they faced formidable opposition from the slaveholders of the South and Slave Power, an alliance of “proslavery presidents, the Supreme Court, and Southern Senators and congressmen all intent on nationalizing the institution and overturning the Founders’ dream⁴¹⁴ of putting slavery on the path to ‘ultimate extinction.’”⁴¹⁵

The early abolitionists were among the first not only to recognize the gross injustice of slavery but also to take action to redress the injustice and they were ordinary people, free men⁴¹⁶ and women⁴¹⁷ as well as former slaves,⁴¹⁸ of diverse backgrounds and

⁴¹⁴ By the time of the Constitutional Convention in 1787 some of the former colonies (now states) had already acted to abolish slavery. Twelve states (all but Rhode Island) sent delegates to the Constitutional Convention in Philadelphia in 1789. Of these twelve, four had already taken action to abolish slavery and two more were considering legislation to do so. Half of the states, however, were committed to retaining slavery indefinitely. The polarity between North and South was pronounced. If a central government were to be formed, and if the states were to achieve union as one nation, then the institution of slavery would have to be sanctioned and protected. Thus, in spite of the fact that many leaders considered slavery to be an immense problem, compromise was reached because union was necessary to secure the nation’s borders, shore up the nation’s shaky credit, and attract foreign investment to build and diversify the economy. Union won out over an inchoate desire to end slavery and the Framers of the Constitution met most of the Southerners’ demands to protect and sanction slavery, including the “three-fifths clause,” which counted three fifths of a state’s slave population in apportioning presidential electors and congressmen. In spite of the protection provided for the institution, the Constitution did not include the words “slave” or “slavery.” For general background information on slavery during the Revolutionary War and in the time leading up to and including the drafting of the Constitution, see Davis, *Inhuman Bondage*; David Brion Davis, *The Problem of Slavery in the Age of Revolution* (New York, NY: Oxford University Press, 1999); Don E. Fehrenbacher, *The Slaveholding Republic: An Account of the United States Government's Relations to Slavery*, edited by Ward M. McAfee (New York, NY: Oxford University Press, 2001); *Beyond Confederation: Origins of the Constitution and American National Identity*, edited by Richard Beeman, Stephen Botein and Edward C. Carter II (Chapel Hill, NC: The University of North Carolina Press, 1987). The synthesis is mine.

⁴¹⁵ Davis, *Inhuman Bondage*, p. 262.

⁴¹⁶ Theodore Weld, passionately committed to reform, was the son of a Connecticut minister. Wendell Phillips, who was converted to the cause of reform by the revival and became one of the most powerful and eloquent white abolitionist orators, was a New England aristocrat, a Harvard graduate and an attorney. Elizur Wright, a trained minister who became an outspoken atheist, was an early convert to abolitionism who at first passionately supported apolitical moral suasion but later turned to political abolitionism. See Bruce Laurie, *Beyond Garrison: Antislavery and Social Reform* (New York, NY: Cambridge University Press, 2005), pp. 17-19.

⁴¹⁷ The Grimké sisters, Sarah and Angelina, left their home in South Carolina and moved north when they could no longer tolerate living with slavery but were powerless to do anything about it. See Gerda Lerner,

temperaments. They were committed to the cause of redressing the injustice of slavery, worked indefatigably to spread the antislavery message across the Northern states, and were indispensable to the eventual success of the work of abolition. However, these early abolitionists, although absolutely committed to the cause of abolishing slavery, worked in relative isolation from one another, without any coherent plan for persuading other individuals and eventually the government to take the necessary action to free the slaves and eradicate the institution of slavery as a social, economic, and politically protected entity in America.

B. A Leader Emerges

However, in 1831 one individual emerged as leader of the work to abolish slavery in the United States and this one man stood out as the principle leader of the work from 1831 to 1865. With the emergence of this leader, William Lloyd Garrison, the general feeling that slavery was evil, an injustice against the slaves that needed to be redressed, coalesced into America's first social reform movement. Called the "great agitator," Garrison was "the leading voice for the civil rights of African Americans, far ahead of anyone else in opposition to Jim Crow [laws], and without equal when it came to raising

The Grimké Sisters from South Carolina: Pioneers for Women's Rights and Abolition (New York, NY: Oxford University Press, 1998). Lucretia Mott was a Quaker lay preacher and Biblical scholar who led the founding of the Philadelphia Female Anti-Slavery Society. Lucy Stone, a Massachusetts teacher and the first female graduate of Oberlin College, who was brought into the abolition movement by the Grimké sisters, was an editor and a paid field agent who lectured on the subject of antislavery. See Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery* (New York, NY: St. Martin's Press, 1998), Chapters 9-11.

⁴¹⁸ Frederick Douglass was a fugitive slave who wrote and lectured on abolition and became the most famous black leader of the nineteenth century. Sojourner Truth also fled slavery and became a leading advocate of abolition. The black abolitionists, particularly the refugees from slavery, "performed the indispensable task of translating the abolitionists' abstract images into concrete human experience...[and undermined] the belief that most slaves were treated kindly." Davis, *Inhuman Bondage*, p. 259.

awareness of racial injustice and reminding the nation of its egalitarian heritage.”⁴¹⁹

William Lloyd Garrison, editor and publisher of a weekly newspaper, *The Liberator*, “a sterling and unrivaled example of personal journalism in the service of civic idealism,”⁴²⁰ laid the groundwork for social change and forced the nation to confront the most crucial moral issue in its history. Garrison honed the issue of the injustice of slavery into a message demanding immediate emancipation with equal rights for all slaves, and inspired two generations of activists. Working together, they built a social reform movement that was “a collaboration of ordinary people, stirred by injustice and committed to each other, who achieved a social change that conventional wisdom first condemned as wrong and then ridiculed as impossible.”⁴²¹

Garrison thought of himself as an agitator and produced *The Liberator*, weekly for thirty-five years⁴²² without interruption, as a newspaper of agitation in which he broke the silence that was the tacit premise on which American political life rested, spoke openly and scathingly of the evils of slavery and racial prejudice, and made the public listen in a way that no one had before him. He was a hero to his black readers, who were

⁴¹⁹ Laurie, *Beyond Garrison*, p. 124.

⁴²⁰ Mayer, *All on Fire*, p. xiii.

⁴²¹ Mayer, *All on Fire*, p. xiii.

⁴²² Garrison chose Boston, the birthplace of liberty, as his center of operation and produced the first issue of *The Liberator* on January 1, 1831 and the last on December 29, 1865 after the Thirteenth Amendment constitutionally abolished slavery. When Garrison, who was twenty-five years old, started his newspaper, Abraham Lincoln was a twenty-one-year-old sodbuster on the Illinois prairie; Jefferson Davis was a newly commissioned U.S. Army officer fighting the Sauk and Fox on the Wisconsin frontier; Robert E. Lee, Davis’s West Point classmate, was building federal batteries on the Georgia coast; Ulysses S. Grant and William T. Sherman were schoolboys in Ohio; Harriet Tubman was a ten-year-old field hand on a Maryland slave plantation; John Brown was teaching school and running a tannery in Pennsylvania; Stephen A. Douglas was reading law in western New York; Frederick Douglass was learning to read as an adolescent slave in Baltimore; and Harriet Beecher Stowe was teaching composition in her sister’s Hartford Female Seminary. A generation later, the lives and careers of each of them would be profoundly shaped and even redirected by the process Garrison set in motion. See Mayer, *All on Fire*, p. 112.

the sustaining force of the newspaper's first year, but he was despised by slaveholding editors and politicians and even reform-minded leaders when he refused to moderate his views and instead increased the tempo of his attacks. The hostility toward Garrison demonstrated that he was beginning to influence the people, to turn them, if not toward immediate emancipation with full civil rights, then at least away from tacit acceptance of slavery. The hostility also emphasized how desperately the abolitionists needed an organization

C. Structure and Organization

Garrison began campaigning for a national organization, to direct and concentrate the moral strength of the converts to the cause of abolition, in the third edition of *The Liberator*. Early response was favorable but his supporters were intimidated by organized efforts to suppress Garrison and withdrew their support. Undeterred, Garrison worked to start a regional organization. The New England Anti-Slavery Society (NEAS),⁴²³ the first in the nation committed to both immediate emancipation and the establishment of equal rights, was born early in January 1832 in the basement of a black church.

Garrison and the American abolitionists faced a number of daunting obstacles including the sheer size of the problem and the racist ideology that permeated American thought. The Constitution⁴²⁴ itself was a problem. And the American political system,⁴²⁵

⁴²³ The principles of the NEAS included immediatism, that every person has a right to immediate freedom; justice, that "man cannot, consistently with reason, religion, and the eternal and immutable principles of justice, be the property of man;" (Mayer, *All on Fire*, pp. 130-31) and judgment, that anyone who holds a fellow human being in bondage is guilty of grievous wrongdoing.

⁴²⁴ The Constitution counted three-fifths of the slave population in apportioning congressional representation and thus gave an advantage to the slaveholding states. It also pledged to defend states

a morass of patronage and spoils, corruption, slaveholding veto power, and compromises at odds with morality or religion, represented a fourth major obstacle. Garrison was more exhilarated than discouraged by the challenges.

The work of the NEAS attracted several thousand new members and more than a dozen local affiliates. Moreover, fifty local groups, from northern Maine to western Ohio, had modeled their organizations on that of NEAS. The need for a national organization became more apparent as the cause of abolition grew rapidly. The much-needed national organization that would help the movement gain strength was finally founded when leading abolitionists met in Philadelphia in early December 1833 and formed the American Anti-Slavery Society (AAS). Garrison drafted a declaration of the principles of the nascent organization, following the model of the Declaration of Independence.⁴²⁶

D. Opposition

The movement gained momentum⁴²⁷ after the founding of the AAS, but the growth was interspersed with violence and every step forward meant ostracism, verbal

against insurrection and assist in the recapture of runaways, and guaranteed that each state had control over its domestic concerns. These Constitutional provisions produced a federal consensus that slavery was a protected institution and could not be regulated or abolished in the states where it existed.

⁴²⁵ The political parties focused on building the intersectional coalitions necessary to win presidential elections and expanded the philosophical consensus to include a practical code of silence. Slavery became known as the peculiar institution, not because it was morally or theologically offensive, but because it was considered to be the local and particular concern of the masters. Southerners would not participate in national politics unless the slavery issue remained off limits.

⁴²⁶ The AAS pledged to organize abolition groups, sponsor agents, circulate tracts, purify the churches, enlist the press, and act in support of the Christian and constitutional duty to remove slavery by moral and political action. They made this pledge standing on the truths of the Declaration of Independence and Divine Revelation. See Mayer, *All on Fire*, pp. 171-7.

⁴²⁷ The women of Boston had formed a female antislavery society that quickly attracted an impressive membership from both races. Divinity students at Lane Seminary in Cincinnati, led by Theodore Weld,

retaliation, and physical abuse. Garrison considered the hostility to be a sign of how much impact the movement was having on society.

The leaders of the AAS worked out a plan of cooperation with state affiliates to govern the protocol of fund-raising, the dispatch of agents, and the distribution of pamphlets and tracts, and state organizations joined the AAS as auxiliaries. The AAS planned a saturation campaign using the mail to get the antislavery message to remote locations to prepare the way for agents and organizers and to ministers, legislators, and editors in the South where it would be too risky to send field agents.

The saturation campaign generated a powerful counterattack that included a demand from Southern leaders to enact federal laws to exclude from the mails “all printed papers *suspected of a tendency* to produce or encourage an insubordinate and insurrectionary spirit among the slaves in the South”⁴²⁸ and a further demand for Northern support for this legislation.

Garrison believed he had a moral obligation to repudiate slavery and free the slaves and no government could impose limits on it. He proposed a new politics of universal justice in opposition to the old politics of union and compromise. In five years, Garrison had made himself heard and raised the public awareness of slavery so that they could no longer ignore the issue.

held an eighteen-day revival on the question of slavery and the entire student body was converted to immediatism. Lane Seminary tried to expel Weld and issued new rules for the student body that forbade abolition activities at the school. Weld and the divinity students resigned in a body, founded a new school committed to free speech (Oberlin College), and went on the road as abolitionist lecturers. See Robert H. Abzug, *Passionate Liberator: Theodore Dwight Weld and the Dilemma of Reform* (New York, NY: Oxford University Press, 1980), Chapters 5-7.

⁴²⁸ Mayer, *All on Fire*, p. 197.

E. The Issue

For Garrison and his followers, the issue was always that slavery was immoral and unjust and therefore all slaves should be immediately emancipated and granted the full equal rights of citizenship.⁴²⁹ As a step toward achieving that goal, the AAS organized a petition drive that called on Congress to abolish slavery in the District of Columbia and sent the signed petitions to Washington, D.C. but Congress impose a “gag rule,” that “forbade printing or discussing petitions related to slavery; such documents would be silently consigned the oblivion of being ‘laid on the table.’”⁴³⁰ The AAS strongly condemned Northern supporters of the rule and editors who had once been hostile to the cause of abolition denounced the suppression of public opinion. The groundswell of support for the abolitionist movement continued and accelerated.

In Congress, John Quincy Adams was an outspoken supporter of the antislavery message but no comparable antislavery voice emerged in the Senate. John Calhoun of South Carolina was the most determined and implacable of slavery’s advocates and therefore the most obdurate and relentless enemy of the abolitionists. Garrison recognized Calhoun as a formidable defender of slavery, as absolute in his defense as Garrison was in his defense of freedom and equality. In the 1830s Garrison was “the

⁴²⁹ Garrison provided a precise but high-level of what abolition meant. Abolition meant the immediate emancipation of all slaves with full and equal civil rights to be guaranteed to the freed slaves and their descendents in perpetuity. This definition did not extend to any plan on implementation. That is, the definition of abolition was what had to be done but not how to do it.

⁴³⁰ Mayer, *All on Fire*, p. 217.

only man north of the Mason Dixon line willing to challenge Calhoun's brazen logic and declare the issue to be one of right and wrong."⁴³¹

In spite of the opposition, the abolition movement continued to grow and, to capitalize on their success the AAS sponsored a three-week session⁴³² to train field agents. Garrison attended and met two women who would not only remain ardent abolitionists but would also be instrumental in starting the second great American social reform movement for woman's rights and suffrage. The women were Sarah and Angelina Grimké, sisters from South Carolina, who had chosen Northern exile rather than continue to live surrounded by the plantation slavery they abhorred but were powerless to change.

F. New Levels of Opposition

The sisters lectured in antislavery meetings in New York and Massachusetts, usually to mixed audiences of men and women, and quickly aroused the active opposition⁴³³ of the clergy. Clerical opposition sparked new interest in the cause and the abolition movement continued to grow, but as women worked more fully for the cause of abolition, the movement began to fracture. Liberal abolitionists were willing to embrace radical social change that included woman's rights as well as immediate emancipation

⁴³¹ Mayer, *All on Fire*, p. 218.

⁴³² It was necessary to bring these new workers together both to build the communal spirit so necessary to their dangerous work and also to train them to be effective as field agents. The agents-in-training attended three sessions each day to work through an abolitionist curriculum addressing "slavery as a moral wrong, the shortcomings of colonization and gradualism, conditions in the South, the needs of the free black population, and the relationship between prejudice and abolition." Mayer, *All on Fire*, p. 230.

⁴³³ Before the advent of the Grimké sisters, the clergy, although not supporting abolition had been relatively passive, that is, did not actively oppose the movement or the abolitionists. After the sisters began their work, the clergy actively opposed the movement, the abolitionists, and especially the women activists.

with full equal rights as citizens for the slaves. Conservative abolitionists, however, wanted the issue of slavery resolved without disturbing the established structure of power.

As the movement grew so did the opposition, and violence became more prevalent. Garrison responded to the escalating violence by embracing radical pacifism and advocating nonresistance.⁴³⁴

G. Dissension Within the Movement

By the time of the AAS annual meeting in May 1839, abolitionists had separated into two distinct groups. A conservative political-clerical coalition supported only a limited vision of the movement that did not include either woman's rights or nonresistance, favored political action, and thus opposed Garrison. The radical abolitionists, by far the majority, embraced an expanded vision of the movement that included woman's rights as well as immediate emancipation with full equal civil rights and at least considered nonresistance to be a viable option. They supported Garrison in most of his ideas, considered him to be the abolition movement's greatest asset, and wanted to keep the movement open to all so that the real work, at the grassroots level, could still be done. They believed, with Garrison, that political influence could be exercised in a variety of ways and anticipated the time when abolition and the ballot box would come together to overturn all laws that supported slavery. They understood, as many others did not, that the moral transformation of the people was necessary before

⁴³⁴ Advocates of nonresistance would neither hold office nor vote but would nevertheless obey all requirements of the government except those contrary to the Gospel message and they would submit to the penalty for any disobedience. A century later, Mahatma Gandhi and Martin Luther King, Jr. would expect to prevail through preaching as Garrison had and would demonstrate the effectiveness of nonresistance.

political reformation could happen for without moral change electoral change would be useless.⁴³⁵ In 1840 the growing rift in the abolition movement fractured into formal schism. Garrison and the radical abolitionists retained control of the AAS while the conservative political-clerical coalition formed a separate American and Foreign Anti-Slavery Society.⁴³⁶

Garrison and the radical abolitionists, including Frederick Douglass, a fugitive slave⁴³⁷ who became an MAS agent, began to embrace direct social protest against the racial injustice that was a corollary to slavery and succeeded in desegregating Massachusetts railroad lines and steamers. The successful protest against the Jim Crow transportation laws coincided with another victory for the abolitionist movement in the *Amistad* case.⁴³⁸ The *Amistad* case was a triumph for humanitarianism and a triumph of the abolitionists' ability to work together but did little to get rid of insidious racial prejudice and nothing to undermine the constitutional system that supported slavery. The *Amistad* case was followed by a series of fugitive slave cases⁴³⁹ that brought Americans

⁴³⁵ Garrison also understood that political change would also be necessary for moral change to be effective.

⁴³⁶ The new society entered the political arena as the Liberty Party but was not successful in promoting its candidates. The political wing of the abolition movement would eventually make some impact as the Free Soil Party. Garrison, however, remained the acknowledged leader of the abolition social reform movement.

⁴³⁷ When Douglass spoke, he put a face on the evils of slavery. Most audiences had no firsthand experience of slavery and had never before heard an escaped slave speak for himself in public about the cruelties he had experienced and witnessed as a slave. People who could not relate to slavery in the abstract could relate to the personification of slavery.

⁴³⁸ The *Amistad* was a Baltimore-built schooner that was operated by Spaniards who were involved in the Cuban slave trade. In the summer of 1839, the captive African slaves commandeered the ship, killed the captain, and ordered the navigators to return the ship to West Africa. The navigators deceived the rebels and gradually moved northwest toward the United States where the U.S. Navy seized the ship, charged the Africans with murder and piracy, and had them confined to a New Haven jail. For more information on the *Amistad* case, see Davis, *Inhuman Bondage*, Chapter 1; Mayer, *All on Fire*, Chapter 15.

⁴³⁹ See Mayer, *All on Fire*, pp. 310-13.

face-to-face with the reality of the fugitive slave laws. Slavery was being made a matter of national, not local, interest.

H. Disunionism

Garrison believed it was time for abolitionists to come out of the Union that was built on compromise and contradiction and began to advocate the idea of disunion. He proposed that the citizens of the free states “demand the repeal of the Union or the abolition of slavery, not as a threat but as a moral obligation.”⁴⁴⁰ Garrison was not threatening political secession⁴⁴¹ but pointing out the inevitable collapse of a nominally free society built on the contradiction of slavery and ordinary citizens began to question openly the value of the Union. The abolitionists were intent on teaching Americans how to make a moral revolution, a permanent revolution of opinion, understanding that from moral revolution would come first political revolution⁴⁴² and then the laws that would emancipate the slaves and extend to them their full civil rights.

I. New Levels of Support

New supporters began to promote abolition. Slowly the churches began to speak out against slavery and, in the Methodist and Baptist denominations, this precipitated schism between North and South.⁴⁴³ As Southern clergymen became increasingly shrill

⁴⁴⁰ Mayer, *All on Fire*, p. 313.

⁴⁴¹ John Calhoun repeatedly threatened secession to frighten Northerners into maintaining the Constitutional compromise with slavery.

⁴⁴² Garrison in particular understood that there was a political dimension to the cause of abolition and that no change would — or could — come about without political action. And he was fully capable of participating in mainstream politics without sacrificing his radical views or independent position.

⁴⁴³ When the Methodists refused to install a slaveholding bishop and the Baptists refused to employ slaveholding missionaries, angry Southerners formed the Southern Methodist and Southern Baptist

in their defense of slavery, Northern clergymen became more committed to speak out against it.

Insurgency in the churches reinforced the interaction of conscience and sectionalism in politics. With more than half a million square miles ceded to the United States by the treaty that ended the Mexican War, the question of whether slavery would be prohibited or protected in the new territories began to be debated.⁴⁴⁴ All the territorial positions accepted the basic proposition that Congress did not have the power to interfere with slavery. Radical abolitionists, however, had a different position, disunionism, that rejected the constitutional compromise in favor of a thorough political reconstruction. Garrison's disunionist position, though seldom recognized in political discussion, exerted a subterranean influence that would make itself felt during the civil conflict that was still a dozen years in the future.

J. Free-Soil Party

The rising tide of antislavery dissent in the churches and sectional politics culminated in a convention of Free-Soil advocates who were not radical abolitionists but conscience-driven moderates who could no longer tolerate evasion on the antislavery

churches. Southern clergy and lay leaders felt that "Northern fanaticism had led to wholesale condemnation of slaveholders as sinners and abandonment of traditional policy of maintaining silence on divisive questions of social policy." See Mayer, *All on Fire*, p. 376.

⁴⁴⁴ Several major positions emerged in regard to the question. Northern politicians favored the idea of free-soil, with outright congressional prohibition of slavery in the new territories. Southern politicians favored congressional noninterference on the grounds that Congress had no power to interfere with slavery as a matter of property rights and state equality. However, though Congress had no power to prohibit slavery, Southerners maintained that Congress had the duty to protect slaveholding in the new territories. A third position was to extend the Missouri Compromise line westward to the Pacific Ocean, in which case nearly all the territory ceded by Mexico would be open to slavery. A fourth position, popular sovereignty, advocated letting the people of each territory decide but this raised collateral questions about how the decision would be made, whether by a handful of initial settlers or the population at the time the territory was ready for statehood, and whether by the territorial legislature or by statewide referendum. See Mayer, *All on Fire*, pp. 378-85.

issue. They became the party that superseded the Liberty Party and produced the first significant break in the two-party system. The Free-Soil Party affirmed congressional power to prohibit slavery in the territories but completely ignored the Liberty Party's pledge to support full equality of rights for all.

Garrison welcomed the Free-Soil Party⁴⁴⁵ as the beginning of the end of the great compromise with slavery but warned that the new party was nothing more than a token of progress. Not extending slavery into the new territories was noteworthy but it would not liberate a single slave. Veteran abolitionists applauded the exodus from the slavery parties but pointed out that the real issue of immediate and universal emancipation had not yet been reached. Garrison warned that abolitionists had to reiterate the message of immediatism and equality and return to the methods that had begun to make an impression on the moral conscience of the nation: homegrown agitation and grassroots organizing.

K. Compromise of 1850

When California petitioned to join the Union, another civil crisis erupted. The newly drawn constitution specifically prohibited slavery in the state of California. Thus, when admitted to the Union, California would tip the balance of the Senate toward free soil and ensure that the Wilmot Proviso⁴⁴⁶ would be applied to the remainder of the territory ceded from Mexico.

⁴⁴⁵ Because of the personal animosities at the time of the schism in the abolition movement, Garrison never recognized the Liberty Party.

⁴⁴⁶ The Wilmot Proviso, a rider tacked on to an appropriations bill, prohibited the introduction of slavery into any of the Mexican territory to be acquired with the appropriated funds. See Mayer, *All on Fire*, p. 362.

The crisis over the admission of California as a free state was resolved by a complex set of compromises, known as the Compromise of 1850. For those who defended the compromise, the watchwords were obedience, order, and the necessity of complying with laws enacted by the democratic majority. But for abolitionists and antislavery dissenters, the watchwords were conscience, freedom, and the moral duty of opposing an oppressive exercise of power in a system so corrupt that the slaveholding minority called the shots for the majority.

In a speech in the Senate, William Seward referred to a higher law than the Constitution, the “universal principles of the Creator and the common heritage of mankind”⁴⁴⁷ and this became a shorthand for the antislavery opposition to the constitutional protections afforded to slavery. Northerners adopted the phrase and began to realize that in order to fulfill their obligation to the higher law, they would have to do something about the Constitution. This was akin to Garrison’s idea of disunion. For him, the fact that people were questioning their relationship to the constitution, whether as higher law or disunion, meant that the radical abolitionists were making progress.

In the early 1850s, Harriet Beecher Stowe⁴⁴⁸ wrote and published a novel that dramatized the furor over the increasingly stringent fugitive slave laws and helped countless numbers of people to understand the agony and injustice of slavery itself in addition to facing the reality of the treatment of fugitives. The novel, *Uncle Tom’s Cabin*, became “the most popular antislavery novel the world would ever know.”⁴⁴⁹

⁴⁴⁷ Mayer, *All on Fire*, p. 413.

⁴⁴⁸ Harriet Beecher Stowe was the daughter of Garrison’s clerical nemesis, Lyman Beecher.

⁴⁴⁹ Mayer, *All on Fire*, p. 418.

Stowe made a vast white audience sympathize with the human aspirations of black people and in so doing made the unseen visible.⁴⁵⁰

Ordinary people who had not necessarily supported slavery but had passively accepted the status quo changed their attitude in response to *Uncle Tom's Cabin*. The novel opened up a space in which abolitionists could speak with those who disagreed or who had formerly been passive or apathetic, and field agents worked very hard to keep the conversation going. While they kept the antislavery issue alive, they also recruited a number of converts to the cause of immediate emancipation with full equal rights. The abolition movement had made slavery the overriding question of the generation.

IV. American Abolition and Antislavery

As the nation expanded westward, the issue of slavery became intertwined with expansionism. The Missouri Compromise of 1820-21 had prohibited slavery north of the 36°30' North latitude for all of the territory acquired in the Louisiana Purchase and also provided that states would be admitted to the Union in pairs of one free and one slave so that the balance of power between free and slave would be maintained in the Senate.⁴⁵¹ However, in the aftermath of the annexation of Texas and the acquisition of the territory ceded to the United States by Mexico, the issue of the expansion of slavery arose again, and the Kansas-Nebraska Act of 1854 repealed the Missouri Compromise. The Act

⁴⁵⁰ Stowe made the issue of slavery in general, and fugitive slaves in particular, real as no one else had. Her novel became America's greatest literary phenomenon of the nineteenth century, selling more than three million copies in its commercial lifetime in the United States. British editions and translations into every European language added an equal number or more. See Mayer, *All on Fire*, pp. 417-24.

⁴⁵¹ The so-called balance of power was at best illusory. Since the proslavery faction dominated the executive branch of the government, and since the President of the Senate, who cast the deciding vote in case of a tie, was the Vice-President of the United States, the balance of power would shift toward the slave states.

created a surge of public anger greater than anyone could remember because the guarantee of two generations that prohibited slavery in the northwest had ended.

Garrison emphasized the moral wickedness of slavery itself. Slavery and liberty were diametrically opposed and mutually exclusive ideas that could not coexist in America. The institution of slavery must be abolished and all slaves must be emancipated and granted their full equal civil rights. Armed only with righteous conviction⁴⁵² and intending to foment a spiritual revolution, Garrison challenged government to live up to its ideals more than any one ever had.

V. The Republican Party

The Republican Party solidified its position as the most credible opponent of arrogant slaveholders and emerged as the one that would first crack the coalition that gave slaveholders the upper hand. Garrison accorded the Republicans a measure of respect he had never extended to the Liberty Party⁴⁵³ but cautioned that it was the duty of abolitionists to avoid becoming Republicans⁴⁵⁴ because the work of abolition would not be accomplished by adopting the model of politics. Rather, the work of abolition would be accomplished by creating a redemptive vision of what could be in the minds and hearts of individuals.

⁴⁵² In support of his conviction, Garrison burned a copy of the U.S. Constitution (and other related and equally hated documents such as the Fugitive Slave Act), an act reminiscent of Martin Luther's burning of canon law and the papal bull that excommunicated him. It was Garrison's most dramatic statement, the pinnacle of his career of agitation, not a symbolic protest but a substantial statement of the work that needed to be done.

⁴⁵³ Republicans were politicians who acknowledged moral principles whereas those of the Liberty Party were moralists who lowered themselves to partisan activities.

⁴⁵⁴ However, Garrison believed that it was the duty of all Republicans to become abolitionists.

Garrison knew that social reform begins in the heart of a solitary individual who perceives what needs to be done and persists until it is accomplished. Solitary individuals of like mind would become the movement that would accomplish the great work of social change. The task of genuine abolitionism was to raise the consciousness of the Northern public to a moral standard that the Republicans would be bound to honor without subterfuge or delay.

A. *Dred Scott* Decision

In early 1857 the Supreme Court handed down its decision in the *Dred Scott*⁴⁵⁵ case, a ruling that further and fatally unsettled the nation and brought it closer to the Civil War that would finally resolve the issue of slavery. The *Dred Scott* ruling delivered the dual opinion first, that Congress had no authority to exclude slavery from the territories and second, that black people had no constitutional rights of citizenship. The first ruling, taking the most extreme Southern view of the territorial question, made the Missouri Compromise and all subsequent restrictive legislation unconstitutional. The second ruling, taking the most extreme white supremacist view of the moral question, reinforced the concept of chattel slavery and the constitutional recognition of a slaveholder's property rights. *Dred Scott* marked a new aggressiveness in the defense of slavery, not on the usual grounds of the peculiar Southern institution, but as a national political entity, entitled to national protection.

⁴⁵⁵ Dred Scott was the slave of a U.S. Army officer who was taken by his master from the slave state of Missouri to the free state of Illinois, then to the free territory of Wisconsin, then back to Missouri, where his master died in 1846. With the help of abolitionist lawyers, Scott sued for his freedom in court, claiming that he should be free because he had lived on free soil for a long time. The case went all the way to the United States Supreme Court and the Court's ruling became known as the *Dred Scott* decision.

B. Abolition and Republican Politics

For Garrison, the entire struggle for emancipation and equal rights had to be understood as one of conscience against organized injustice. He had always understood that his moral suasion had political consequences and now had to balance his high principles against the practical possibilities of Republican politics.

The abolition movement had transformed the nation's conscience but would not get the laws changed or the Constitution reconstructed. In the American system, that work would have to be done by politicians and Garrison was pragmatic enough to understand and accept this. The best way to make the message of immediate emancipation with full equal rights felt in party politics was to build a strong base of abolitionist public opinion and bring the antislavery voters to a higher understanding of what had to be done. Garrison did not want all abolitionists to become Republicans but he did want all Republicans to become abolitionists.

VI. Abraham Lincoln

The great showdown between North and South began with the most splintered presidential campaign of the century followed by a cataclysmic challenge of the results. Abraham Lincoln, different from every other candidate since John Quincy Adams because he considered slavery to be a moral issue,⁴⁵⁶ a question that could have only one right answer and therefore would have to be resolved in accordance with the higher law

⁴⁵⁶ Lincoln had attacked his opponent's moral indifference to slavery and reiterated the Republican willingness to condemn slavery as an evil, the true difference between the parties. He had repeatedly said that the entire controversy rested on each section's moral view of slavery and, if slavery was wrong then it could neither be extended nor continue to be protected.

of conscience, was elected president. The election was a strike against slavery, although not yet a victory for freedom.

A. Secession

The South immediately prepared to leave the Union. The secession threat that had been made so often that it was considered a rhetorical device became a reality in December 1860 when South Carolina⁴⁵⁷ was first to secede from the Union,⁴⁵⁸ followed quickly by Georgia, Florida, and the four Gulf States.

Garrison welcomed the break in the covenant and condemned all efforts aimed at saving the Union. The slaveholders had broken the covenant when it no longer worked to their advantage and now the free states could reconstruct it on a moral basis. It was far more important to do what was morally right than to engage in a shabby compromise to save the Union.

B. Civil War

Although Lincoln, in his inaugural address, attempted to conciliate the South, six weeks later the Confederates fired on Fort Sumter and the Civil War began. At the outset of the war, only the radical abolitionists raised the question of whether it was a war to restore the old compromised Union or a war to reconstruct the nation on a moral basis, uncompromised by slavery. Garrison's position was that the rebellion had dissolved the

⁴⁵⁷ At the Constitutional Convention, South Carolina was the most vociferous in demanding protection for slavery. The threat at that time was that they would not accept the Constitution. In the intervening three-quarters of a century, South Carolina had continued to be outspoken in demanding increased protection for the South's peculiar institution. For additional information on South Carolina's demands at the time of the Constitutional Convention, see James Madison, *Notes of Debates in the Federal Convention of 1787: Bicentennial Edition* (New York NY: W.W. Norton & Company, Inc., 1987).

⁴⁵⁸ South Carolina cited the existence of abolitionist societies as one of its chief grievances. See Mayer, *All on Fire*, pp. 514-17.

Union and presented the opportunity for a new birth of freedom and a reconstructed Constitution.

Garrison's abolitionism and pacifism were in conflict but, since agitation and politics had converged and made emancipation a viable prospect, he was willing to contend in the practical arena. He endorsed the war because it presented a historic political opportunity that was too great to ignore. The work of the abolitionists was still to create a public demand for immediate emancipation with full equal rights, focusing on three large tasks. First, to distinguish abolitionist disunion from secession; second, to compel public opinion to recognize that slavery was the cause of the war⁴⁵⁹ and to make abolition one of its goals; and third, to find a constitutional approach to emancipation that was compatible with both Republican conservatism and Lincoln's reluctance to antagonize the border states.⁴⁶⁰

Garrison pressed the logic of warfare to its ultimate conclusion, suggesting that Lincoln, as Commander-in-Chief, had the authority under the Constitution to regard slavery as a military threat.⁴⁶¹ By invoking his wartime powers, Lincoln could emancipate the slaves and thus deprive the enemy of an important military and economic resource. Perhaps the argument for emancipation because of military necessity would

⁴⁵⁹ The South made it very clear that they were fighting for slavery. Alexander Stephens, Confederate vice-president, candidly declared that the Confederacy would rectify the fundamental error of the Declaration of Independence. The cornerstone of the new government rested on the foundational truth that the Negro was not equal to the white man and that slavery was his natural condition. See Mayer, *All on Fire*, pp. 523-25.

⁴⁶⁰ The Border States, Missouri, Kentucky, Maryland, and Delaware, were slaveholding states that were still in the Union.

⁴⁶¹ See Mayer, *All on Fire*, p. 526.

have more effect on public opinion than the argument for emancipation because justice required it.

Abolitionists continued to keep their message of immediate emancipation with full equality in front of the public. Individual groups began to merge into a true mass movement to promote support for emancipation and Republicans began to engage in joint ventures with the abolitionists.⁴⁶² The abolitionist argument gained an extended and respectable hearing.

C. The Emancipation Proclamation

Although Lincoln seemed to be ambivalent,⁴⁶³ he had actually made his decision regarding emancipation as a military necessity, but was waiting for a Union victory in battle before announcing his intention to issue an Emancipation Proclamation. When victory came at the Battle of Antietam on September 17, 1862, Lincoln summoned his Cabinet and announced to them that it was time for him to issue a Preliminary Emancipation Proclamation. The edict was a military pronouncement that converted the Union forces into an army of liberation. Lincoln first affirmed that on January 1, 1863, “all persons held as slaves within any state, or designated part of a state, the people whereof shall then be in rebellion against the United States, shall be then, thenceforward,

⁴⁶² In Boston, an Emancipation League was formed as a mainstream lobbying effort and it immediately began educational programs to lobby the public. An intensive petition campaign, the greatest mobilization since the original petition drives of the late 1830s, was organized and directed toward the next session of Congress. Other Emancipation Leagues, patterned after the Boston example, were created in other cities and the petitions poured into Congress.

⁴⁶³ At times Lincoln stated that his paramount objective was to save the Union, with or without freeing the slaves, but at other times he spoke of the primary importance of emancipation. See Mayer, *All on Fire*, pp. 537-41.

and forever free.”⁴⁶⁴ Then, in the revolutionary heart of the message, Lincoln ordered all military and naval authority “to recognize and maintain the freedom of such persons, or any of them, in any efforts they may make for their actual freedom.”⁴⁶⁵

On New Year’s Day, no one knew what to expect. No advance text had come from Washington for the morning papers and no one knew when — or even if — word would come that the final proclamation had been signed and promulgated. Garrison and his family attended an afternoon Jubilee concert at the Music Hall where the mood was festive but the crowd was nervous. As yet no bulletin had arrived to justify the celebration. It was a society gathering, the people of property and standing who had come very slowly and grudgingly to abolition. After the program had begun word finally arrived that President Lincoln had signed the proclamation and the Music Hall erupted in pandemonium. When someone called three cheers for Garrison, the whole crowd saluted the man who, against all odds and in the face of grave danger, had done so much to make this happen.

The next morning Garrison rushed to his office at *The Liberator* and discovered that the proclamation was better than expected. It not only freed the confiscated slaves of rebels but emancipated all the slaves in the rebel states and would extend military protection to them and accept their enlistment in the Union’s armed forces. Lincoln’s eloquence shone through the somewhat cumbersome and prosaic document when he described the decree as an act of justice, sanctioned by the Constitution because of wartime necessity, and invoked “the considerate judgment of mankind and the gracious

⁴⁶⁴ Davis, *Inhuman Bondage*, p. 317.

⁴⁶⁵ Davis, *Inhuman Bondage*, p. 317.

favor of Almighty God.”⁴⁶⁶ Garrison hailed the event as ““sublime in its magnitude, momentous and beneficent in its far-reaching consequences, and eminently just and right alike to the oppressor and the oppressed.”⁴⁶⁷ But, although this day was the turning point that fixed the destiny of slavery, the mighty work of abolition was not yet done. One million black people were still enslaved in the Border States⁴⁶⁸ and it was to these that the abolitionists turned their attention.

Lincoln had committed the nation to free its slaves by military force and had endorsed the long battle for equal citizenship by opening the door to the enlistment of black troops. The Emancipation Proclamation was like a promissory note that could only be made good if the Union were victorious, but military necessity was not a solid foundation for social transformation. “Universal and lasting freedom required further action not only to end slavery...but to establish a firmer constitutional foundation for abolition than an executive wartime edict.”⁴⁶⁹ The abolitionists mobilized to begin the work for a guaranteed end to slavery that would be a more permanent solution than a wartime edict.⁴⁷⁰

⁴⁶⁶ Mayer, *All on Fire*, p. 547.

⁴⁶⁷ Mayer, *All on Fire*, p. 547.

⁴⁶⁸ In the first five months of 1862, Congress enacted legislation that abolished slavery in the District of Columbia and prohibited slavery in the territories. Thus, only the Border States still recognized slavery.

⁴⁶⁹ Mayer, *All on Fire*, p. 549.

⁴⁷⁰ In the fall of 1863, the AAS called for a new petition drive and also endorsed women’s activism. Elizabeth Cady Stanton and Susan B. Anthony collaborated on this effort, the largest and most successful drive in American history. Stanton was a founder and leading voice in the Woman’s Rights and Suffrage Movement. Anthony was another leading voice for Woman’s Rights and Suffrage. The Stanton-Anthony collaboration would continue for the remainder of their lives. See Chapter 7 of this dissertation.

Garrison the visionary developed a genuine respect for Lincoln and supported his renomination for he understood, as others did not, that the incumbent Lincoln had to win the upcoming presidential election in order to consolidate the victory of emancipation.

D. Thirteenth Amendment

By the time of the November 1864 election, the outcome of the war had turned in the Union's favor, Lincoln won by half a million votes, and the Republicans achieved a seventy-five percent majority in Congress. Honoring a pledge made to Garrison, Lincoln moved immediately to secure passage of the Thirteenth Amendment.

Lincoln used all of the lobbying power and political muscle available to him to secure passage of the Thirteenth Amendment. Whatever deals were made, or whatever understandings were reached about patronage or favors, have never been revealed. The lobbying worked. The House passed the measure on January 31, 1865, with two votes to spare. The final vote was 119-56, with sixteen Democrats joining all one hundred three Republicans.

Writing for *The Liberator*, Garrison called the passage of the Thirteenth Amendment “the greatest and most important event in the history of Congressional legislation.”⁴⁷¹ A few days later, speaking to a Jubilee celebration, Garrison praised all the abolitionists and antislavery people who had worked so hard for so long to abolish slavery. He hailed the majority of the public who had at long last decided on a radical change that brought the promise of the Declaration of Independence into the Constitution as the supreme law of the land. And he raised a cheer to Abraham Lincoln for breaking

⁴⁷¹ Mayer, *All on Fire*, p. 576.

the chains of millions of the oppressed. No praise was more welcome to Lincoln than the words of “his old critic, the fiery abolitionist William Lloyd Garrison.”⁴⁷²

E. Aftermath of Emancipation

Garrison was a guest of the government for the ceremonies at Fort Sumter commemorating the end of the war. As he traveled in the South, he came to understand that the task of Reconstruction would be enormous.⁴⁷³ The liberated slaves in refugee camps would have to be resettled and all the former slaves would have to adjust to living as free persons, adapt to the changed situation in relation to their former masters, and learn to read as well as the other skills necessary to be self-supporting and assume the burdens of citizenship.

Garrison had instigated a revolution that at the beginning had seemed to be a social and political impossibility but he had seen the impossible become real. He understood the magnitude of the work ahead but would not participate in it. The Thirteenth Amendment was ratified in November and the Constitution was proclaimed amended on December 18, 1865. In the last edition of *The Liberator*, dated December 29, 1865 Garrison spoke of the years of work and his pride in what had been accomplished. But he also affirmed that there was much work yet to be done and many wrongs against the former slaves to be redressed. With the publication of the last edition of *The Liberator*, Garrison retired.

⁴⁷² Doris Kearns Goodwin, *Team of Rivals: The Political Genius of Abraham Lincoln* (New York, NY: Simon & Schuster, 2005), p. 690.

⁴⁷³ The abolition movement had never agitated on this phase of abolition. They had advocated immediate emancipation, i.e., what to do, but had never addressed how to accomplish it. Reconstruction was the “how to do it” phase of abolition and Garrison understood the enormity of the work to be done.

In 1866, Congress addressed the two most glaring constitutional anomalies created by the abolition of slavery, black citizenship and the three-fifths clause. The Fourteenth Amendment superseded the *Dred Scott* decision and created a “national guarantee of equality before the law that could be enforced against the states in federal courts.”⁴⁷⁴ It made explicit what Garrison and the abolitionists had thought was implicit in the Thirteenth Amendment. The second section of the Fourteenth Amendment negated the three-fifths clause in regard to congressional representation. Henceforward representation would be based on the whole number of persons in each state but reduced in proportion to the number of adult male citizens denied the vote.

The Fifteenth Amendment forbidding both federal and state governments from denying the vote because of race, color, or previous condition of servitude passed Congress in 1869. When it was ratified, the AAS finally declared its work at an end and dissolved the organization.

VII. Why Examine Abolition?

It has been said that those who do not study history are condemned to repeat it.⁴⁷⁵ Slavery, its existence and Constitutional protection, and the social reform movement that succeeded in abolishing the institution of slavery, are important parts of American history and as such should be studied and understood.⁴⁷⁶ It is important to remember not only

⁴⁷⁴ Mayer, *All on Fire*, p. 605.

⁴⁷⁵ This is a paraphrase of a quote from George Santayana: “Those who cannot remember the past are condemned to repeat it.” George Santayana, *The Life of Reason*, Great Books in Philosophy (Amherst, NY: Prometheus Books, 1998), p. 82. It is necessary not only to remember the past and study history but also to understand and learn from the past and from history.

⁴⁷⁶ I do not mean to imply that the United States will once again permit slavery and grant it Constitutional protection (although nothing is beyond the realm of the possible). Rather, it is important to remember that, although America was not always the land of the free, a small group of dedicated individuals took the

that the United States once permitted and protected slavery but also that the American people took the necessary action to abolish the institution and remove its Constitutional protection. The American people recognized injustice in the tyranny of taxation without representation in the late eighteenth century and took action, the Revolutionary War for Independence, to end it. The American people again recognized injustice in the institution of slavery in the nineteenth century and again took action, this time in a social reform movement for abolition to end it. If the American people of past centuries could act to change history, then the American people of the present and future should also be able to change history. The abolitionists were pioneers in fomenting reform through a social reform movement but contemporary reformers can learn from the successes of the past to direct reform movements of the future.

VIII. Abolition as a Social Reform Movement

A social reform movement⁴⁷⁷ is a form of social protest that enables ordinary people to make collective claims on authorities, public or private, and achieve objectives without resorting to the violence of a bloody revolution. It is a distinctive way of pursuing public politics that includes sustained, organized public campaigns, a repertoire of political practices, and public representations of worthiness, unity, numbers, and commitment on the part of reformers, their constituents, and their cause. Social movements are an invented and distinctive form of contentious politics, contentious because they involve the collective making of claims that conflict with the interests of

action necessary to bring the Constitution into agreement with the rights promised in the Declaration of Independence.

⁴⁷⁷ For a more complete explication, see Chapter Five of this dissertation. See also Charles Tilly, *Social Movements, 1768-2004* (Boulder, CO: Paradigm Publishers, 2004), Chapter 1.

others and politics because governments are almost always involved, usually as the object of the claim. When authorities are unable or unwilling to act to redress injustice, people, ordinary citizens, form social movements to effect necessary reforms.

A social movement develops from and consists of a synthesis of three elements: a campaign, a repertoire of political action, and a continuing public display of worthiness, unity, numbers, and commitment (WUNC). A *campaign* is a sustained, organized public effort that makes claims on target authorities and extends beyond a single event and always includes at least the group making a claim (the proponents of social reform), the object of the claim (usually, but not always, the government), and the public. The interaction among these entities constitutes a social movement.

The *repertoire* consists of a number of forms of political action, all intended to get the message out in front of the public, to arouse more individuals to support the movement, and to persuade the objects of the claim to take action to resolve the issue. The integration of the political repertoire into a sustained campaign is integral to a social movement and differentiates it from other varieties of politics.

Continuing public displays of *WUNC* (worthiness, unity, numbers, and commitment) keep the issue and the message in front of the public in a form they can recognize and relate to.

The integration of these elements — campaign, repertoire, public displays of WUNC (worthiness, unity, numbers, and commitment) — and sustainable collective action separate a social movement from other forms of contentious action. Social movements maintain their challenge of the status quo regardless of fierce opposition and

even violence. This ability to interact with powerful opponents and at the same time maintain identity and sustain collective action is the mark of a social movement.

A. Hallmarks of Social Reform Movements

Thus, the hallmarks of a social reform movement include ordinary people protesting social injustice, making claims on authorities, and achieving objectives without violent revolution. In pursuing reform, social reform movements utilize sustained public campaigns, a variety of political practices, and continuing displays of worthiness, unity, numbers, and commitment. Social reform movements make claims that conflict with the interests of other parties, resolve their claims through the political process, sustain their claims over a long period of time, and maintain their challenge of the status quo regardless of the extent of opposition. How then does Abolition match these characteristics of social reform?

B. Social Reform Attributes and Abolition

Abolition began with a small group of ordinary people who protested the status quo, specifically the existence and Constitutional protection of slavery in the United States. This group of ordinary people made their claims, that all slaves should be immediately emancipated and granted full and equal civil rights, against government and slaveholders and achieved their objectives without resorting to the violence of a bloody revolution.⁴⁷⁸

The social reformers who came to be known as abolitionists sustained their campaign for the immediate emancipation of all slaves with the granting of full and equal

⁴⁷⁸ The opponents of abolition started the Civil War, not the abolitionists.

civil rights to the newly-emancipated slaves for a period of more than thirty-five years. The campaign for abolition was a very public effort, with meetings and rallies, and lectures delivered in meeting halls, churches, and public squares. In addition to meetings and lectures, the reformers conducted petition drives and letter-writing campaigns, wrote and distributed tracts and pamphlets, and formed associations to organize the efforts and further the work of abolition. The reformers demonstrated worthiness, unity, numbers, and commitment to the cause by continuing to agitate for immediate emancipation with full equal rights in spite of hostile and even violent opposition and despite persistent efforts to silence them and prevent them from achieving their objectives.

The reformers claimed that slavery was wrong, unjust, and in violation of the promises of the American Declaration of Independence and their claims conflicted with the interests of the slaveholders, the government, and most if not all of the public. Yet, the abolitionists worked to transform the minds, hearts, and consciences of all who were not committed to the cause of abolition, to convert them to the cause through moral suasion. When they had acquired a critical mass of support for abolition, the reformers then shifted their focus to the political process, to elect the individuals who could and would enact the laws to reflect the transformed consciences of the American people. They continued to challenge the status quo of slavery despite fierce opposition from slaveholders, government, the public, and even, at least for several years, the churches and clergymen. In the face of overwhelming, Constitutionally protected opposition, the

abolitionists persisted until the slaves were emancipated and the Constitution was amended to abolish slavery and grant equal rights to the newly-emancipated.⁴⁷⁹

Thus, in regard to overall high-level criteria, abolition measures up well to a social reform movement. It did what a social reform is intended to do, that is, achieved social reform through contentious politics without violent revolution. Therefore, since Abolition was a social reform movement, the first such movement in American history, what lessons can be learned from it? These lessons can be applied to future efforts at social reform such as a movement to effect comprehensive reform of the American health care system.

IX. Lessons to be Learned from Abolition as a Social Reform Movement

Abolition was a social reform movement, not only in the respect that it accomplished change but also in how it achieved that social reform. By examining the work of abolition, valuable lessons can be gained, lessons that can be applied to future efforts at social reform. This section will examine the Abolition movement to determine what lessons can be learned. However, it must be noted that the most important lesson of all is to begin the work of reform. Once the work has begun, other lessons can then be drawn.

A. Leadership

The first lesson to be learned from abolition is the importance of leadership.⁴⁸⁰

The idea of abolishing slavery certainly did not begin with William Lloyd Garrison. As

⁴⁷⁹ The Thirteenth Amendment abolished slavery, the Fourteenth Amendment granted equal rights, and the Fifteenth Amendment gave Negro men the right to vote.

early as 1693, Philadelphia Quakers were beginning to speak out against slavery, at least within their own communities. By the end of the Revolutionary War, the Northern states were committed to emancipation. At the time of the Constitutional Convention, four of the twelve states present had already taken action to abolish slavery and two more were considering legislation to do so.⁴⁸¹ But the desire to end slavery was at best inchoate until a leader emerged and began the work to focus the desire into a force for action. This leader, William Lloyd Garrison, would remain the symbol, the voice, and the conscience of the abolition movement until the slaves were emancipated and the institution of slavery was abolished by Constitutional amendment.

Like all social movements, abolition began at the grassroots level, from the bottom up. A leader emerged, again at the grassroots level, and began to take the action necessary to awaken the public to the need for reform, to build public support, and to focus public support into a force for political action. Grassroots level organizing and work was and would remain essential to the cause of abolition from the beginning of the movement until its eventual success.

Although many other leaders⁴⁸² emerged to do the work in communities throughout the Northern states and western territories, Garrison remained the principal

⁴⁸⁰ The emergence of a leader marked the beginning of the social reform movement. The idea of the need for social reform had existed for many years.

⁴⁸¹ For a more complete discussion of slavery in colonial North America and the early days of the Republic, see Davis, *Inhuman Bondage*, Chapters 6 and 7.

⁴⁸² Theodore Weld, for example, was a lifelong abolition activist. He led the 18-day revival meeting at Lane Seminary that resulted in the mass conversion of the entire student body to the cause of immediatism and precipitated the founding of Oberlin College. Weld also organized and conducted the 3-week convocation to train new field agents in November 1836 where the Grimké Sisters from South Carolina met fellow abolitionists and received the training that would help them become leaders of the movement. Other leaders included Wendell Phillips, Lewis Tappan, and Lucretia Mott among many others, not all of whom are remembered by history.

leader of the abolition movement for thirty-five years. He founded his own newspaper, *The Liberator*, as a vehicle for agitating the issue of abolishing slavery and honed the desire to end slavery into the issue of emancipation and formulated the message of immediate emancipation with full equal rights for all slaves. Garrison kept the message alive and made the public aware of the evils of slavery, stirred up public opinion, and eventually caused turbulence among the uninformed, the apathetic, the passive, the opinion makers, the elites, and the opposition, most especially among the opposition.

B. Structure and Organization

A second valuable lesson to be drawn from the abolition movement is the importance of structure and organization. After work had begun at the grassroots level, and new adherents began to join the cause for reform, local organizations began to be formed, and a structure began to be defined.⁴⁸³ Later regional and national organizations were founded in order to coordinate the work of the various local organizations.

Multiple organizations formed at multiple levels and all had one goal, to abolish slavery in the United States.⁴⁸⁴ One group advocated the immediate emancipation of all slaves with the granting of full and equal civil rights to the newly emancipated slaves, although even within this group⁴⁸⁵ not all agreed on how to accomplish the goal. This

⁴⁸³ One way of measuring the growth of the abolition movement was by counting the numbers of new organizations that formed at local levels.

⁴⁸⁴ Not all had the same approach to achieving the goal of abolishing slavery. Some, for example, advocated the gradual emancipation of slaves while others advocated the colonization of emancipated slaves outside of the United States.

⁴⁸⁵ It should be noted that even within this group that advocated immediatism — the immediate emancipation of all slaves coupled with the granting of full and equal civil rights — there were differences of opinion in how this should be achieved. One group favored political action — electing candidates who

group that favored immediate emancipation through the moral suasion that led to political action is the focus of this chapter of the dissertation.⁴⁸⁶

The national organization helped to focus the work of the regional and local organizations and to concentrate the moral strength of the converts to the cause of immediate emancipation. Regional associations worked with both local groups and national organizations to raise funds, arrange lecture schedules, and distribute literature from the national group to the local organizations, and conducted meetings and delivered lectures as well. Local groups worked with their communities on lecture campaigns, petition drives, meetings, both formal and informal, and conducted all the day-by-day business necessary to keep the message alive and the movement growing.

The structure was comparable to the federated structure of American government but it was not the strict hierarchical structure of a bureaucracy. Rather, it was a cooperative effort, within the limitations of time and distance.⁴⁸⁷ As the idea of societal reform through the abolition of slavery began to take hold of the public imagination, structure became increasingly important. Anyone who sought information about abolition or who was prepared to support the work knew where to turn. At the same time, the multi-level organizational structure provided a better utilization of skills and

favored abolition — from very early on, while another group favored “moral suasion” — transforming the minds and hearts of the people — before turning to political action.

⁴⁸⁶ This group definitely made the most radical demands but they were ultimately successful. They did not waver in their demands and they did not change their fundamental message throughout the thirty-five years of the campaign to abolish slavery. It is because they were the most radical, and the most implacable in their demands, that they deserve to be studied and remembered.

⁴⁸⁷ In this twenty-first century of instant communications, it is difficult to imagine what communication among the abolitionists must have been. They had no telephones, email, or instant messaging; no radio or television; no twenty-four hour news source. Yet they managed to get the message out and accomplish a change that was first condemned as wrong and then ridiculed as impossible

scarce resources than would be possible if every organization had to build up a complete set of skills and fend for itself.

The abolition movement was more than merely the organizations that comprised it. Organizations would fracture and fracture again, but the movement continued and grew. Furthermore, the competing organizations would work together when the situation called for cooperation.

C. The Issue, the Message, and Identity

A third lesson, equally important as leadership, structure, and organization, is the composite of the issue, the message, and identity. The issue and the message were closely intertwined. The issue was that slavery was wrong, unjust, and contravened the promise of the Declaration of Independence.⁴⁸⁸ Therefore both the institution of slavery and its Constitutional protection had to be abolished. Within the abolition movement, various groups advocated different ways of accomplishing this goal. However, William Lloyd Garrison, the acknowledged and controversial leader⁴⁸⁹ of the abolition movement, honed the issue into the message that was a demand that all slaves be immediately emancipated and granted full and equal civil rights. He began to proclaim this message, a precise definition of the issue, in the very first edition of *The Liberator*, and he repeated it for thirty-five years. The message was a succinct statement of the issue but it was not an implementation plan: the message stated what needed to be done, but not how to do it.

⁴⁸⁸ “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness. See *The Declaration of Independence and the Constitution of the United States of America*, edited by Cato Institute (Washington, D.C.: Cato Institute, 2002), p. 9.

⁴⁸⁹ In Italian we would say Garrison was the *capo di tutti capi*.

The radical abolitionists understood the message as it was precisely defined but, as the cause attracted more adherents, not all either understood or were prepared to accept immediate emancipation with full and equal rights. Many who considered themselves to be antislavery actually opposed the extension of slavery into the western territories. Garrison welcomed them into the fold of the abolition movement for they helped to increase the level of turbulence that would eventually force the government to act and worked to persuade them that slavery was just as wrong in the states as it would be in the territories.

Identity refers to the people on whose behalf social reform is advocated.⁴⁹⁰ The abolition movement advocated on behalf of the slaves who were a definite and easily identified group within the larger population⁴⁹¹ because all slaves were black, although not all blacks were slaves. The identity of the people on whose behalf social reform was advocated was included in the message, i.e., immediate emancipation of all the slaves. Former slaves and fugitive slaves such as Frederick Douglass and Sojourner Truth helped to give a personal identity to those on whose behalf abolition was advocated.

D. Symbols

Symbols, closely allied to identity, represent another important lesson to be learned from abolition. The abolition movement made use of a variety of badges,

⁴⁹⁰ Identity is important because it creates a bridge between the abstract idea of social reform and the concrete reality of the people who are suffering because of injustice. Thus, while it is important to identify specific individuals who are working for and/or benefiting from social reform, it is equally important to identify the whole group or class of beneficiaries, even if their individual names are not known. People – supporters and potential supporters – respond more readily to the concrete than to the abstract.

⁴⁹¹ Identity could be more problematic in a contemporary social reform movement, such as a movement to reform the American health care system. Possibly the only way to avoid the problem of identifying those on whose behalf health care reform was advocated would be to make it universal: health care reform is needed for all Americans.

engravings, and insignia. Garrison depicted a slave auction block against a backdrop of the American flag waving above the United States Capitol on the masthead of *The Liberator* to remind readers of the incongruity of slavery in a land conceived in liberty. In *Uncle Tom's Cabin*, Harriet Beecher Stowe made the unseen visible and created a powerful symbol of both the humanity and the suffering of slaves. But the most powerful symbols of the evil and degradation of slavery were the former and fugitive slaves, such as Frederick Douglass, Sojourner Truth, and their brethren.⁴⁹²

E. Communications

A fifth important lesson, one related to both the composite of issue, message, and identity, and the symbols that depict the composite, is the importance of powerful communications. In an era when they could not possibly have even imagined the communications capability available in the twenty-first century, a small but extremely dedicated and determined group of people created a social reform movement that aroused public opinion sufficiently to overturn a socioeconomic system that had existed at the beginning of recorded history and for the entire lifetime of the land that became the United States. This group of people, the abolitionists, accomplished reform that many thought was impossible by formulating the message of what needed to be done and communicating their message to the public repeatedly, until the public finally began to pay attention.

The primary leader of the abolition movement, William Lloyd Garrison, honed the message to a statement that the slaves must be immediately emancipated and granted

⁴⁹² The former and fugitive slaves put a human face on the abstraction of slavery and made the horror of the institution palpable to the American people.

full and equal civil rights. He founded, edited, and published his own newspaper, *The Liberator*, for the specific purpose of conveying this message to the American people, and he published the newspaper every week for thirty-five years. The message was simple and direct, eloquent in its simplicity, and ultimately effective, although it took more than thirty years of agitation and repetition before its effect began to be felt and a full thirty-five years for immediate emancipation to be reflected in the Constitution.⁴⁹³

F. Other Lessons to be Learned from Abolition

Other lessons can be learned from the fact that the abolitionists sustained their public campaign, in the face of formidable opposition, for more than thirty-five years and inspired a second generation of reformers in the process, from the repertoire of practices that abolitionists developed and refined, from their public displays of worthiness, unity, numbers, and commitment, and from their opposition.

1. Sustained Public Campaign

The thirty-five year existence and weekly publication of *The Liberator* is one measure of the sustained nature of the campaign to abolish slavery. The opposition that was aroused, even to the point of violence, marks this campaign as public as well as sustained. The AAS existed even longer than *The Liberator*, from its founding in 1833

⁴⁹³ It was another three years before the Fourteenth Amendment, guaranteeing equality before the law, was ratified, and two more years beyond that for the Fifteenth Amendment, enfranchised black men. It was another fifty years before black women, and all other American women, won the right to vote. And it was not until the middle of the twentieth century that many of the rights granted in law to the emancipated slaves and their descendants began to be granted in fact to them.

until it disbanded after the Fifteenth Amendment was ratified in 1870, and its long existence⁴⁹⁴ exemplifies the sustained and public nature of the abolition campaign.

2. Repertoire of Practices

The abolitionists developed and refined a wide variety of practices to spread the word of what needed to be done and attract the attention of the policy makers who would have to accomplish the political work that would make the idea of immediate emancipation with full and equal rights a legal reality. They wrote and distributed tracts and pamphlets, and delivered lectures in a wide variety of places, including village squares, meeting halls, and churches. They organized and conducted petition drives and sent the petitions to Congress.⁴⁹⁵ The abolitionists held rallies, conventions, meetings, picnics and other events to exchange ideas, give one another much needed moral support, and attract new adherents and they developed tactics for direct social protest.⁴⁹⁶

3. Public Displays of Worthiness, Unity, Numbers, and Commitment (WUNC)

The abolitionists demonstrated their worthiness, unity, numbers, and commitment in a variety of ways, such as their repudiation of all violence and their willingness to persevere in the face of formidable opposition that included mob violence. The growing number of subscribers to *The Liberator*, the increasing numbers of organizations and the expanding membership of each, and the vociferous strength of the opposition all indicate

⁴⁹⁴ Even after internal dissension led to schism within the national organization, the work continued, and the opposing groups were able to cooperate with each other, thus sustaining the effort to abolish slavery.

⁴⁹⁵ Because of the gag rule, the petitions were not acted on, but the abolitionists continued the work, certain that eventually the gag rule would be lifted and the petitions would then provide support for the cause.

⁴⁹⁶ In the twentieth century, this direct social protest would become known as nonviolent resistance, but the practices had their roots in the abolition movement of the nineteenth century. Consider Mahatma Gandhi's 'march to the sea,' or the Civil Rights 'freedom riders.'

that the effect of the abolition movement was being felt. The abolitionists joined together in meetings, conventions, picnics, and other social events, all indications of unity.

Furthermore, the movement continued without pause, even at the time of the internal dissension and schism within the national organization.

4. Opposition to Abolition

Slaveholders and proponents of slavery were fiercely opposed to abolitionists and the abolition movement. Slave Power⁴⁹⁷ was truly formidable opposition, for it meant that the United States government was prepared to defend and perpetuate the institution of slavery. The Constitution sanctioned and protected slavery⁴⁹⁸ and thus placed the highest law of the land in opposition to abolition. Business, civic, political, religious, and social leaders opposed abolition, as did newspaper editors.⁴⁹⁹ Yet, despite the overwhelming power of the opposition — political, social, and financial — arrayed against them, this small group of people, a collaboration of ordinary citizens with no power of their own, were stirred by the injustice of slavery and committed to one another and to the cause of abolition. Working together, without backing down on their demands and against all odds, they achieved what is arguably the greatest social change in the history of the American republic. Their perseverance in the face of such daunting opposition provides a most critical lesson for future reformers.

⁴⁹⁷ Slave Power was an alliance of proslavery presidents, the Supreme Court, and Southern senators and congressmen.

⁴⁹⁸ The Constitution counted three-fifths of the slave population in apportioning congressional representation and thus gave an advantage to the slaveholding states; pledged to defend states against insurrection and assist in the recapture of runaways; and guaranteed that each state had control over its domestic concerns.

⁴⁹⁹ It seemed that everyone except the slaves and the abolitionists opposed abolition.

X. Applying Lessons Learned from Abolition as a Social Reform Movement

In order to apply the lessons learned from abolition as a social reform movement, it is necessary first to begin the work. Leadership will then emerge, either from the very first to recognize the need and begin the work, or from the early converts to the cause of reform. Leadership may come from a single individual, or from several individuals, who may or may not be like-minded, in different grassroots locations. Thus, for leadership to emerge and be effective, there must be something and someone to lead.

Very quickly a structure will begin to develop because people are more comfortable with structure than with chaos. As structure develops, groups should make use of what they have learned in other situations to create an organization that will optimize the use of resources available to the cause. In contemporary American society, nearly everyone has some experience with organizational structure, whether from working in the business world or from dealing with government bureaucracy. This knowledge and these skills should be applied to creating an efficient organization for the social reform movement.

In defining the issue to be agitated and formulating the message to present the issue to the public, a future social reform movement should follow the trail blazed by abolition and define the issue and message as radically as possible. When others were advocating colonization or gradualism, Garrison and the radical abolitionists were insisting on immediate emancipation with full and equal rights. They knew that they had to demand equal and exact justice in order to get even partial redress. If they demanded anything less than justice, they would get nothing at all. Thus, a contemporary reform movement should make its demands comprehensive and radical, in order to ensure that

they achieve even partial reform. Then, having defined the issue and formulated the message to deliver it, contemporary reformers should, as the abolitionists did, stick to that message until reform has been accomplished.⁵⁰⁰

Contemporary reformers should establish some form of official communications, analogous to *The Liberator*. In an era of instantaneous communications, it is all too easy for misinformation to be acquired by the media and passed along as fact. Therefore, reformers should establish some source of official information⁵⁰¹ that will be available to all and ensure that the information source is always timely and accurate.

Having begun, a contemporary social reform movement will have to be willing and able to sustain the campaign in the face of anything and everything, from public apathy to opposition hostility or even violence. The repertoire of practices and public displays of worthiness, unity, numbers, and commitment will develop and grow out of the sustained campaign but contemporary social reformers will have to persevere.

XI. Conclusion

American slavery was abolished because a few people recognized injustice and the need for reform, the government protected the institution rather than acting to redress the injustice, and these ordinary citizens took action through a social reform movement, the first in American history. They stirred up public opinion and raised the consciousness of their fellow citizens, aroused the wrath of the proponents of slavery, and in the process brought the injustice and need for reform into focus for policy makers. The abolition

⁵⁰⁰ Even if contemporary reformers should disagree among themselves, it is essential to present a united front to the public, to potential supporters, and to opponents.

⁵⁰¹ It does not have to be a newspaper, but it should be easily accessible, perhaps an information hotline or a website. It is easier to provide accurate information than to put out the fires caused by misinformation.

movement sustained its campaign for more than thirty years, but succeeded in gaining both emancipation and equal rights for the slaves.⁵⁰²

A number of valuable lessons can be learned from abolition, including the importance of leadership, structure and organization, the issue and the message, and communications. William Lloyd Garrison, primary leader of the abolition movement, defined the issue as one of injustice: the institution of slavery and the Constitutional protection of the institution, were unjust and had to be abolished. He honed the issue into the message that was a demand that all the slaves be immediately emancipated and granted full and equal civil rights and he communicated this message repeatedly in *The Liberator*, the newspaper he founded for that specific purpose. The work continued for more than thirty years and was ultimately successful in gaining freedom for the slaves.

A contemporary social reform movement will likewise need leadership, structure and organization, an issue and message, and timely and accurate communications. It will also have to contend with the identity factor, that is, those for whom reform is being agitated. Identity was not a problem for abolition, since all the slaves were easily and readily identifiable. The day-to-day problems of a contemporary social reform movement may be somewhat different than those encountered in the past, but the work will be as daunting and the opposition as fierce as anything the abolitionists faced. Contemporary reformers should be armed with as much information as possible about previous social movements, in order to gain from their experience and avoid their errors. Therefore, the next chapter of this dissertation will examine Woman's Rights and

⁵⁰² Emancipation was gained in fact, but equal rights, although granted in law, would require another civil rights movement a century later in order to be recognized in fact.

Suffrage, the second great American social reform movement, to determine what lessons can be learned from that effort.

Chapter Seven

Woman's Rights and Suffrage as a Social Reform Movement

I. Introduction

In keeping with the thesis of this dissertation, that a social reform movement is called for in order to effect comprehensive reform of the American health_care system, and having examined abolition, the first attempt in the United States to redress injustice through a social movement, it is now appropriate to examine the second such social reform movement, Woman's Rights and Suffrage. Both of these social movements began in the nineteenth century, although Woman's Rights and Suffrage required two decades of work in the twentieth century in order to accomplish its goals. Abolition and Woman's Rights and Suffrage, the first two social movements in American history, both succeeded in accomplishing comprehensive reform and redressing injustice without resorting to violent revolution. The woman's rights and suffrage movement however, although it originated in and grew out of the abolition movement, developed differently than abolition.

The position of women in society was somewhat different than that of the slaves, for, unlike the slaves, women were part of the family structure. Thus, despite their slavlike subordination in a patriarchal society, women were not considered property under the law and therefore could begin to work toward acquiring other human rights,

such as civil and property rights, independent of the right to vote, and without first overcoming the onus of existing as chattel property. For the slaves, all other rights were subordinate to freedom, the right to liberty, and for this reason, the abolition campaign agitated for immediate emancipation and then the granting of full and equal rights to the newly emancipated. For women, this was not the case. Activists worked to gain for women a variety of civic, legal, and property rights, most of which were independent of each other. Many rights for women were fought for and won apart from and both prior to and concurrent with the formal Woman's Rights and Suffrage movement. Suffrage, the right to vote, was actually the last of the rights granted to women in response to the Woman's Rights and Suffrage social reform movement and was the direct result of the movement.

II. Prelude to the Woman's Rights Social Movement

Questions of equality of women had been raised as early as 1634⁵⁰³ but the questions and incidents were too sporadic to become any kind of organized movement.⁵⁰⁴ Beyond that, women had not yet won the right to be educated, the right to speak in public, or the right to receive the same pay as a man for similar work. The struggle to attain these rights began prior to the beginning of any formal social movement. The work

⁵⁰³ For more on the position of American women prior to 1800, see Eleanor Flexner, *Century of Struggle: The Woman's Rights Movement in the United States* (Cambridge, MA and London, UK: The Belknap Press of Harvard University Press, 1975), Chapter I.

⁵⁰⁴ The narrative in this section is included to demonstrate that the work to secure equal rights for women began prior to and continued concurrent with the beginning of a formal social movement. This is somewhat different than the effort to secure freedom for the slaves. A social movement to reform the American health care system would probably develop according to the Woman's Rights paradigm more than the Abolition paradigm although both of the early social movements provide valuable lessons for contemporary reform activists.

was done by women who in contemporary times would be called goal- or results-oriented — women who saw what needed to be done and did it.

A. The Right to be Educated

Education for women was the first aspect of broader rights, and therefore broader opportunities, to become an important issue. The drive to educate women took place within the broader structure of the effort to educate the citizenry, but women were particularly handicapped by the universal belief that the female brain was smaller than the male brain and therefore inferior in quality.

In an 1818 pamphlet, Hannah Mather Crocker,⁵⁰⁵ argued that both sexes were equal in the power of the mind so that, if women were given the same type of education as men, they could accomplish just as much. The following year Emma Hart Willard⁵⁰⁶ developed a systematized course of study for women and submitted a proposal to the governor of New York, outlining novel ideas that would be a turning point in the education of women. In 1821, Willard opened the Troy Female Seminary, the “first endowed institution for the education of girls.”⁵⁰⁷

⁵⁰⁵ See Flexner, *Century of Struggle*, pp. 24-25.

⁵⁰⁶ Emma Hart’s father recognized her talents and worked to obtain the best possible education for her. She particularly loved solving complex mathematical problems but was prevented from studying higher mathematics because of the ancient prejudice that a woman’s brain was too small to handle the strain. This was the catalyst for her work to provide young women with the education that she was denied. It should be noted, moreover, that Emma Hart Willard taught herself the subjects that were denied to her and subsequently incorporated these subjects into her curriculum and taught them to her students. She and her students were all capable of handling the stress of learning complex mathematics as part of a systematized course of study. See Flexner, *Century of Struggle*, pp. 25-30.

⁵⁰⁷ Flexner, *Century of Struggle*, p. 26.

The Troy curriculum was higher education relative to what most young women were taught⁵⁰⁸ but elementary compared to the curriculum available for young men at Harvard and other colleges. Oberlin, founded in 1833, was the first institution to offer women a curriculum remotely comparable to that available to men at the college level.⁵⁰⁹

Mount Holyoke,⁵¹⁰ founded in 1837 with a systematic three-year course of study, cleared the way for the opening of Vassar in 1865, Smith and Wellesley in 1875, and Bryn Mawr in 1885. The significance of Mount Holyoke can hardly be overstated. It proved, in life and in practice, what others had long theorized, “that women’s minds were constituted...the same as those of their masculine counterparts, that given opportunity, discipline, and direction, they could encompass the same subject matter as a man, and that such an education was worth a sizable financial investment.”⁵¹¹ Women were prepared to take their place in the larger society and they went in many directions.

The lingering battle to educate women was fought on behalf of white women. As long as slavery existed, educating the Negro was a threat to the social structure because it disproved the basic premise of racial inferiority that underlay American racial slavery and gave the Negro ammunition to use in the struggle for freedom.

⁵⁰⁸ As the franchise expanded to include all white males over twenty-one years of age, the demand for free education increased in order to prepare a knowledgeable, responsible electorate. These elementary schools began to be open to women. See Flexner, *Century of Struggle*, Chapter II.

⁵⁰⁹ Oberlin’s attitude continued to be that women’s highest calling was to be the mothers of the race so young women were prepared to be intelligent mothers and properly subservient wives, in addition to absorbing the academic curriculum.

⁵¹⁰ For information on Mount Holyoke and other early colleges for women, see Flexner, *Century of Struggle*, Chapter II.

⁵¹¹ Flexner, *Century of Struggle*, p. 36.

B. Women Learn the Art of Social Reform

The struggle to gain for women the right to be educated took place apart from and concurrently with a broad social reform movement to abolish slavery. Thousands of men and women joined the movement and among the women were some of the very first conscious feminists. These women learned the art of social reform in the fight to free the slaves and applied what they had learned to the effort to launch their own social reform movement to secure their own equality. In the antislavery movement, they learned strategy from Garrison and the national leaders, tactics from the leaders of the state level societies, and operational planning from the leaders of the local antislavery societies and from their own work in their communities and with their neighbors.

When the American Anti-Slavery Society (AAS) was founded in Philadelphia in 1833, a few women attended and at least one woman spoke,⁵¹² but women were not permitted to join the society or sign the charter. Immediately after the founding convention, twenty women met to form the Philadelphia Female Anti-Slavery Society and within a few years other women formed similar societies in Boston, New York, and many New England towns. Women were deeply involved in a wide variety of activities as part of the movement to free the slaves, so it is not surprising that many of them became active in the movement to secure greater rights for women, including the right to speak in public.

⁵¹² Lucretia Mott recommended that the pledge of faith would be stronger if two phrases were transposed, so that the delegates stood first on the Declaration of Independence and then on Divine Truth as an everlasting rock. The delegates accepted her recommendation. Mott recalled how one young delegate turned to see the woman who knew the meaning of the word transpose. See Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery* (New York, NY: St. Martin's Press, 1998), pp. 173-77.

C. The Right to Speak in Public

The pioneers were the Grimké sisters, Sarah and Angelina, young women from a South Carolina plantation who had lived with slavery and abhorred it, and so left their home because they were powerless to do anything about it. They were the first to speak in public to a mixed audience of men and women and, when they were condemned for it, fought for and won the right for all women to speak in public before any and every kind of audience. For the sisters, the right to speak in public⁵¹³ was not a matter of abstract justice, but one of enabling them to join in the urgent work to be done. Women could no longer retreat into silence because there was important work to be done and it was incumbent upon them to do it, for the slaves and for themselves.

The right to petition was especially important because it was the only political right that women had under the Constitution. Although Congress had imposed a Gag Rule, forbidding the presentation of any petitions, the campaign for signatures continued and the women who did the work of collecting the signatures were taking a long stride forward for women. They were engaging in a political act, on behalf of others to be sure, but they were also securing a right that they would use later in their own fight for rights. These women were “the first detachment in the army of ordinary rank-and-file women who were to struggle for more than three-quarters of a century for equality.”⁵¹⁴ The first petitions were all about slavery but future petitions would focus on woman’s rights.⁵¹⁵

⁵¹³ The right to speak in public included the right to petition and the right to write. See Flexner, *Century of Struggle*, pp. 44-50.

⁵¹⁴ Flexner, *Century of Struggle*, p. 51.

⁵¹⁵ The fruits of the labor of these countless numbers of anonymous women are stored in file boxes in the National Archives in Washington, testimony to their courageous work.

D. The Right to Equal Pay for Equal Work

The major part of the fight to achieve equal pay for equal work would be fought as part of the labor movement and would ultimately achieve a measure of success, although not until the turn of the twentieth century. The need to wage such a fight, however, became apparent in the nineteenth century when countless numbers of women were entering the workforce but worked longer hours for less pay than men and had no opportunity to improve their skill through training. Women began to take action but were ineffective because they were too weak to negotiate any lasting results. They needed organization with strong leaders who had the intellectual ability and the courage to conduct a systematic campaign, support and assistance, as well as time and money in order to achieve long-term success and this would not come until after the turn of the twentieth century with the growth of the labor movement.

E. The Legal Status of Women

Women began to experience the beginnings of higher education, to emerge as public speakers and antislavery workers, and to initiate rudimentary action to achieve equality in the workplace, but their legal status changed very slowly. They were unable to control their own earnings, manage property that was legally theirs, or sign legal documents. Married women suffered 'civil death' and had no right to property and no legal entity or existence apart from their husbands. A working woman could be forced to turn over her earnings to her husband and have nothing left to live on or to care for her

children even if her husband made no provision for them. A woman had no right to her own children.⁵¹⁶

Finally, although it took years of struggle, between 1839 and 1850 most states enacted some type of legislation that recognized the right of married women to hold property. At this same time there was a growing and perceptible body of public opinion, educated by lecturers and writers, which encouraged the legislative reform.⁵¹⁷

Among the most influential in molding public opinion was Margaret Fuller,⁵¹⁸ who recognized and was not afraid of the sweeping changes required to achieve the goal of equality, wanted women to grow as a nature, to discern as an intellect, to live freely as a soul, and to find and develop whatever powers and talents were given to her. Lucy Stone,⁵¹⁹ an AAS lecturer who was devoted to woman's rights, also helped to mold public opinion. Stone,⁵²⁰ together with her husband Henry Blackwell and their daughter Alice Stone Blackwell, worked nearly the entire span of the woman's rights movement, from 1847 to 1920, to secure the franchise for women.

⁵¹⁶ Even the marriage service spelled out woman's lowly status and subservience. Early reformers simply omitted the 'obey' from the marriage vows.

⁵¹⁷ John Neal began speaking on behalf of woman's rights in 1832 and continued for half a century. Judge Hurlbut, who was converted to the cause when he wrote a paper against it and realized he could refute every point of his argument, wrote a widely circulated pamphlet on *Human Rights*. Sarah Josepha Hale, the editor of the popular magazine *Godey's Lady's Book*, campaigned for higher education for women and for their admission to the professions such as medicine and nursing. See Flexner, *Century of Struggle*, pp. 65-66.

⁵¹⁸ For further information on Margaret Fuller and others who were influential in molding public opinion, see Flexner, *Century of Struggle*, Chapter IV.

⁵¹⁹ For further information on Lucy Stone's influence on Woman's Rights, see Flexner, *Century of Struggle*, PP. 29-30, 68-70, 148-49, 222-23.

⁵²⁰ Critics longed to silence Lucy Stone and hoped that her marriage to Henry Blackwell would do so. Instead the marriage made two, and eventually three, reformers where there had been one.

III. Woman's Rights and Suffrage

Changes were being made, and women were pressing for additional change, but their actions were disjointed because women were isolated from one another so that the overall effort lacked cohesiveness. Grievances, no matter how articulate the speaker or how worthy the cause, will not precipitate a social reform movement. The birth of a social reform movement requires leadership, a program, and a sharp stimulus to focus attention on the work being started, and for the American Woman's Rights Movement this was achieved at Seneca Falls, New York in July 1848.

The seed of the idea that grew into the Seneca Falls convention was planted in the summer of 1840 at the World Anti-Slavery Convention in London, where Lucretia Mott,⁵²¹ an American delegate who was not seated because she was a woman, became teacher and mentor to Elizabeth Cady Stanton,⁵²² the young wife of abolitionist leader Henry Stanton. Mott's "contribution in helping to free the gifted and eager mind of Elizabeth Cady Stanton was an incalculable one, for the younger woman was destined to be the leading intellectual force in the emancipation of American women."⁵²³

Stanton spent the first few years of her married life in Boston but when the family moved to Seneca Falls in the Finger Lakes region of New York, she came face-to-face

⁵²¹ Lucretia Mott was an ordained Quaker minister, an ardent abolitionist, and a well-known and accomplished public speaker. Her home was a busy station on the Underground Railroad and she was the founder of the first Female Anti-Slavery Society. See Flexner, *Century of Struggle*, pp. 71-6.

⁵²² Elizabeth Cady Stanton was the daughter of a well-to-do family who had received the finest education available to women at the time. She had spent many hours in the law offices of her father, who was a judge, learning that women had no legal rights to property or earnings. She would remember the cruelty and injustice of the law all of her life. See Elizabeth Cady Stanton, *Eighty Years and More: Reminiscences 1815-1897* (Boston, MA: Northeastern University Press, 1993), Chapter III; Flexner, *Century of Struggle*, Chapter V.

⁵²³ Flexner, *Century of Struggle*, p. 72.

with the realities of the drudgery and isolation the average woman faced. For the first time she “understood the practical difficulties most women had to contend with in the isolated household, and the impossibility of woman’s best development if in contact, the chief part of her life, with servants and children.”⁵²⁴ The situation was intolerable and she thought to take action by calling a public meeting for protest and discussion.

A. The Movement Begins

In the midst of her turmoil, Elizabeth received an invitation to spend a day with Lucretia Mott who was visiting friends in nearby Waterloo, and in the course of the visit she gave vent to all of her frustration and indignation. The women⁵²⁵ decided to call a meeting and wrote an announcement that appeared in the next day’s *Seneca County Courier*. The Woman’s Rights Convention, to discuss the social, civil, and religious rights of woman, would be held in a Methodist Church in Seneca Falls the following week.⁵²⁶ The women, familiar with the structure of abolition society meetings, drafted a Declaration of Principles following the format of the Declaration of Independence.⁵²⁷ The result was a paraphrase of the original, sentence-by-sentence and paragraph-by-paragraph that served three generations of women reformers and inspired them to gain their rights, including the right to vote, in the face of overwhelming opposition.

⁵²⁴ Stanton, *Eighty Years and More*, p. 147.

⁵²⁵ Five women were present at that historic meeting: Lucretia Mott, Elizabeth Cady Stanton, Martha Wright (Lucretia Mott’s sister), Jane Hunt, and Mary Ann McClintock. The women were seated around a mahogany table that now resides in the Smithsonian Institution in Washington. See Flexner, *Century of Struggle*, p. 74.

⁵²⁶ The women met on July 13, the notice appeared in the newspaper on July 14, and the first Woman’s Rights Convention took place on July 19-20, 1848.

⁵²⁷ Fifteen years earlier, Garrison had also modeled the AAS Declaration of Sentiments on the Declaration of Independence.

Elizabeth Cady Stanton drafted the resolutions to implement the Declaration of Principles and she included a resolution demanding the vote for women. In her first public speech, speaking to an audience of three hundred including forty men, Stanton declared that women had to do their own work to gain their rights because only women could understand the height, depth, length and breadth of their degradation. As the convention proceeded, the resolutions were discussed and passed. Resolution nine, demanding the vote for women, was the only one that did not pass unanimously. At the end of the second day, a third of those present at the convention, sixty-eight women⁵²⁸ and thirty-two men, signed the Declaration of Principles.

Although the Seneca Falls convention in 1848 is considered the birth of the Woman's Rights movement, it had already undergone nearly a half-century gestation period. The women who took the action and brought the ideas to life had vision and great courage. Women had long been dissatisfied with their secondary status and the circumscribed role assigned to them but they had suffered in silence or rebelled in isolation. After the 1848 convention, it was possible for these women to know that they were not alone, "that a movement had been launched...that would leave its imprint on the lives of their daughters and of women throughout the world."⁵²⁹

B. The Movement Grows

The Woman's Rights movement began to grow. After the Seneca Falls convention, a second convention was held two weeks later in Rochester, and a third

⁵²⁸ Among them was 19-year-old Charlotte Woodward, the only one who would live to vote for the President of the United States in 1920. See Flexner, *Century of Struggle*, p. 77.

⁵²⁹ Flexner, *Century of Struggle*, p. 77.

convention a year and a half later in Salem, Ohio.⁵³⁰ Leading abolitionists, including William Lloyd Garrison and Frederick Douglass, were among the women's staunchest supporters.

National Woman's Rights conventions⁵³¹ were held in Worcester, Massachusetts in 1850 and 1852. These national conventions brought the leaders of the emerging movement, including abolitionists Lucretia Mott, Lucy Stone, Abby Kelley Foster, and Angelina Grimké, as well as new figures such as Antoinette Brown, Harriot Hunt, and Sojourner Truth into national prominence.⁵³²

Between 1850 and 1860 national conventions were held every year except 1857 in addition to smaller gatherings at the local level. This gave the impression that the women did nothing but talk but there was not much else that they could do.⁵³³ They had stated their dissatisfaction in the Declaration of Principles. Now they had to agree on what they

⁵³⁰ The most novel feature of the Salem convention was that men were not permitted to speak and thus learned firsthand what it was like to be forced to keep silence when they had questions or comments. This experience would have an influence on the decision to grant women suffrage in the Territory of Wyoming twenty years later. See Flexner, *Century of Struggle*, p. 80.

⁵³¹ The first national convention had an unexpected affect on British social structure when a young English woman published an article in the Westminster Review, recounting the proceedings of the convention and summarizing the case for voting and legal rights for women, which initiated the British effort to improve the status of women. It will be recalled that the British initiated the social reform to abolish slavery and Americans learned from their work. Now British society would profit from work initiated by Americans.

⁵³² Antoinette Brown was an Oberlin graduate who became the first woman to be ordained a minister. Harriot Hunt was a pioneer in the field of medicine. Sojourner Truth was a former slave and well-known abolitionist who was not previously associated with the question of woman's rights. See Flexner, *Century of Struggle*, p. 81.

⁵³³ In her memoirs, Elizabeth Cady Stanton relates some of the specific tasks that she did to keep the message of equality alive and spread it far and wide, including writing articles for the press, letters to out-of-state conventions and private letters to friends to arouse their interest in the movement. She also responded to opponents' criticism, answering their objections to equality for women point-by-point in the newspapers. She gave informal evening entertainment in her home to gather people together to stimulate discussion. In imitation of Margaret Fuller, Elizabeth Cady Stanton also started a weekly discussion group that lasted for several years. See Stanton, *Eighty Years and More*, Chapter IX.

wanted to achieve and to develop an ideology that would serve to refute their critics and win new converts to the cause. They discussed the serious questions of what the proper condition of married women should be, what the woman's place in church, community, profession, and state should be, and on what basis divorce should be permitted. From the gatherings, conventions, and discussions emerged a coherent body of thought, new and dedicated leadership, wide publicity, and new recruits.

The women relied on the abolitionist papers and a succession of journals that they published on their own for the necessary exchange of information and opinion. During the 1850s no permanent organization emerged except a loose steering committee called the "Central Committee." The women were afraid that an organization would be cumbersome and restrict individual effort without providing much gain to the movement and they would not change their opinion until their Civil War experience taught them otherwise.

C. Immediate Concerns of Woman's Rights Movement

With the exception of Elizabeth Cady Stanton, the early Woman's Rights movement showed little interest in obtaining the vote. Their more immediate concerns were control of property, control of earnings, guardianship, divorce, opportunities for education and employment, lack of legal status, and the concept of female inferiority perpetuated by established religion. Without direct input into the legal system, women had no weapon with which to press for reforms so they began to send petitions to state legislatures asking for specific remedial measures. Susan B. Anthony, gifted with political acumen new in a woman and the phenomenal organizational ability to do the work, achieved some outstanding results in New York by organizing the petition drive to

canvass every large city and every county in the state.⁵³⁴ Although it took more than five years of organizing, collecting signatures on petitions, and submitting petitions to the state legislature, in 1860 the New York state legislature enacted a law that gave women the right, in addition to owning property, to collect their own wages, to sue in court, and to have similar property rights at the husband's death as he had when his wife predeceased him.

D. Leadership Emerges

One of the greatest assets of the Woman's Rights movement the working partnership and collaboration of Elizabeth Cady Stanton and Susan B. Anthony whose lives and talents complemented each other. Stanton appreciated the relationship with Anthony who "supplied the facts and statistics, [while I supplied] the philosophy and the rhetoric and together we made arguments that stood unshaken through the storms of long years, arguments that no one has answered."⁵³⁵

Countless others worked to build the movement, the other national leaders plus the innumerable women who became state leaders, and all the women who worked at the local level. The strength of the Woman's Rights movement, as in any other social reform movement, was not just the leadership but the determined devotion instilled in countless numbers of individuals for a century or more. Its greatest asset and true source of wealth reposed in the people who put their lives into it.

⁵³⁴ Susan B. Anthony's contribution to Woman's Rights can hardly be overestimated. As Lucretia Mott typified the moral force of the movement, as Lucy Stone was its most gifted orator, Elizabeth Cady Stanton its outstanding philosopher, Susan B. Anthony was its incomparable organizer, who gave the movement force and direction for more than half a century. Flexner, *Century of Struggle*, pp. 81-5.

⁵³⁵ Stanton, *Eighty Years and More*, pp. 165-66.

The ideas about equal rights for women moved west with the migrants who opened up the frontier and settled the territories. In the South, however, no Elizabeth Cady Stanton or Susan B. Anthony emerged although women faced the same realities as their sisters in the north and west. Yet, from the records of their management of large establishments, it is apparent that many Southern white women had the administrative and organizational ability to direct a reform movement, but no leader emerged and no movement began.

E. New Opportunities

The Civil War created opportunities for women to gain new experiences and women rushed to take advantage of these opportunities. Working with the men who were the leaders of various wartime commissions and projects, women gained their first experience in working in large, complex organizations. They also gained their first experience working in national politics on issues other than their own enfranchisement.⁵³⁶

The onset of the Civil War halted all activities regarding woman's rights and suffrage, a fact that neither Stanton nor Anthony accepted gracefully. They were too accustomed to leadership to fit into the usual war relief work but after the Emancipation Proclamation was issued they got thoroughly involved with the effort to replace the Proclamation with a more permanent guarantee of freedom for the slaves, either federal legislation or constitutional amendment. Stanton, Anthony, and a group of women

⁵³⁶ Civil War work provided unique experiences for women, experiences that would be of great benefit during the long years to gain suffrage. One such experience was working with the Sanitary Commission. The women, who had heretofore resisted structured organization for fear it would restrict individual effort, learned firsthand the value and synergy of working within a structured, well-disciplined organization. Another experience was working directly with national politics on a variety of issues. Although the women were familiar with national political issues because of their work to abolish slavery, they had worked primarily at the local and state level and had not been involved with national politics. See Flexner 1975: pp. 106-110}

activists formed a league to advocate the immediate emancipation and enfranchisement of the slaves as the speediest way to end the war and launched a petition campaign as the most practical way to accomplish the work. They also formed the Women's National Loyal League (WNLL) to act as the focal point for the petition campaign and to serve as a vehicle for woman's rights after the war had ended. The WNLL, pledging one million signatures in support of an emancipation amendment, collected more than four hundred thousand signatures in every state in the North and west, and delivered the signed petitions to the Senate chambers.

The most far-reaching effect of the Loyal League's work was to give women the opportunity to work in an organization and learn how valuable an organization could be as a means to accomplishing their ends. After the war, the Woman's Rights movement would benefit, although not immediately, from this knowledge and experience.

In the Confederacy there were no Loyal League or Sanitary Commission so no leadership developed and no group of women learned how to work together to achieve widely accepted goals although Southern women had the necessary leadership and administrative skills.

The Woman's Rights conventions resumed after the Civil War and women continued to mold public opinion with their articles, lectures, and pamphlets, as well as with their conventions. Structure and organization in the Woman's Rights movement began to solidify when the issue of suffrage became the focal point of their work.

F. Structure and Organization

When the issue of extending the vote to Negro males began to be debated, the leaders of the Woman's Rights movement believed the timing was right to extend the

vote to all women as well but they were politically naïve and “failed to estimate the extent and complexity of the forces arrayed against them.”⁵³⁷ The Republican Party opposed them for fear of jeopardizing two million potential Negro votes. The abolitionists⁵³⁸ deserted them because they did not want anything to interfere with the completion of the great work of abolition, granting equal rights to the Negro.

For Stanton, the time was right for woman’s rights as well as for Negro’s rights and such a time would come only once in a lifetime. She and her supporters sincerely believed that joining the issue of suffrage for Negroes with that of suffrage for women would help both. Others believed that the question of woman suffrage was in its prepolitical stage of preparing the ground and molding public opinion to accept the idea.

Stanton, Anthony, and their supporters were overly optimistic. The question of slavery had been agitated for more than thirty years, a war had been fought to settle the question, and the intensity of feeling was extremely high in favor of finishing the work of emancipation. No such intensity existed in regard to the status of women or the vote for women, even among the women, except for the relatively small group of supporters of Elizabeth Cady Stanton and Susan B. Anthony who failed to see that the political climate was not ready for suffrage for women.⁵³⁹

⁵³⁷ Flexner, *Century of Struggle*, p. 145.

⁵³⁸ Frederick Douglass, the only abolitionist to support Elizabeth Cady Stanton at Seneca Falls, subordinated woman’s rights to the rights of the emancipated slaves. Abby Kelley Foster said that the slaves had been more deeply wronged than woman and therefore the rights of the Negroes would have to be redressed before woman’s rights could be considered. Garrison, who had written and spoken in favor of universal suffrage, accepted the practical limitations of the political situation and referred to universal [male] suffrage. See Mayer, *All on Fire*, pp. 607-12.

⁵³⁹ The Senate had debated woman suffrage as a corollary to a larger bill in 1866. The vote on the question of woman suffrage was 9 in favor, 37 opposed. Much work needed to be done. In Congress, friends of the women’s cause kept the woman suffrage issue alive by introducing a constitutional amendment granting women the right to vote. See Flexner, *Century of Struggle*, pp. 150-2.

G. Two Organizations

Stanton and Anthony had begun to move away from the original woman's rights movement and this precipitated a break in the organization. A May 1869 convention summoned for the sole purpose of discussing woman suffrage was the occasion of the split in the woman's movement when Elizabeth Cady Stanton called for a woman suffrage amendment and the association broke wide open. Stanton and Susan B. Anthony moved quickly and secretly to organize the National Woman Suffrage Association (NWSA) for women only. Membership was open to any woman who believed in suffrage but only those women who were willing to follow the uncompromising politics of Stanton and Anthony actually joined.

In November 1869 a second organization was founded, the American Woman Suffrage Association (AWSA), organized on a delegate basis with only representatives from recognized suffrage associations seated at the convention. It appealed to the women who were emerging into the greater social freedom of the 1870s and were willing to advocate for additional rights for women but were not yet ready to espouse the cause of woman suffrage.

The two suffrage organizations (AWSA and NWSA) operated independently of one another for twenty years. The two groups had extremely different and opposing social viewpoints — the conservative and the radical — and they clashed, but not on whether women should vote but on how to achieve that goal.

The AWSA believed that they had to avoid irrelevant issues that would alienate influential sections of the community and concentrate on the practical work required to

achieve the franchise at the state level. The NWSA advocated for woman suffrage by federal amendment but also looked at woman's rights in the broad sense.

H. Woman Suffrage Migrates West

When the settlers migrated west, they brought with them a legacy of values and a belief system that were in transition. One such value was the dominant attitude that women were destined to a subordinate existence within the home. The realities of frontier life quickly replaced the idea that women should be sheltered. Basic survival demanded that both sexes work very hard for very long hours every single day. Thus, the first real victory for woman suffrage on the American continent came in the west and happened so quietly that nothing was known back east until the battle was over. The Territory of Wyoming, sparsely populated and just taking administrative shape and therefore unencumbered by existing legal impediments, was the first to act. The bill enfranchising women passed the legislature⁵⁴⁰ in 1869 and was sent to the territorial governor who was suspected of opposing the idea and who therefore might veto the bill.

John A. Campbell was the territorial governor and twenty years before he had attended an early woman's rights convention in Salem, Ohio where no man had been permitted to take part or even to speak. He had watched while the women conducted the meeting by and for themselves and the men learned for the first time what it was to suffer in silence. Campbell signed the bill. Women voted in the Wyoming elections of 1870 and 1871 and did not in any way disrupt the proceedings or the results.

⁵⁴⁰ Six to two with one abstention in the Senate, and six to four with one abstention in the lower house.

IV. Political Action

The woman's movement was small and divided but it still displayed considerable creativity, energy, and vitality in the 1870s and 1880s with demonstrations and other legal and political activities. After about ten years, however, it focused on political activity including organizing state suffrage associations, educating public opinion, conducting campaigns for suffrage referenda in the various states, and maintaining pressure on Congress to amend the federal Constitution.

A. NWSA — Federal Level

1. Federal Amendment

The NWSA continued to press for a woman suffrage amendment to the federal Constitution. The first woman suffrage bill had been introduced in Congress in 1868 and had mustered only nine favorable votes. Ten years later a woman suffrage bill that became known as the “Anthony Amendment” was introduced and it would be used, without significant change until Congress finally passed it as the Nineteenth Amendment to the Constitution in 1918. Supporters continued to reintroduce the Anthony Amendment at every session of Congress and hearings were held, usually coinciding with the NWSA annual convention in Washington. When the Senate voted on the question of woman suffrage, the amendment mustered sixteen votes in favor, a gain of only seven votes since the last vote had been recorded. Much more work needed to be done in order to pass a federal amendment for woman suffrage.⁵⁴¹

⁵⁴¹ For additional information on the fight to gain passage of a federal amendment granting woman suffrage, see Flexner, *Century of Struggle*, pp. 171-6.

B. AWSA — State Level

The AWSA worked to enact state level suffrage with the state referendum campaign that achieved few positive results in return for exhausting labor. Woman suffrage could muster devoted workers to respond to a crisis but could not keep them for the long haul because there was no adequate organization to enlist and develop their ability. Without adequate organization in sufficient numbers they could not challenge the deeply rooted prejudice and tradition in the centers of political and economic power. More extensive social progress would be required and many more women, and men too, would have to be mobilized.

However, while universal suffrage, whether at state or federal level, continued to be defeated, limited or partial suffrage was granted in some states. Limited suffrage, while appearing to be a step forward, brought some significant problems for women would become affiliated with political parties and put party loyalty⁵⁴² ahead of woman suffrage.

In 1899 Wyoming sought admission to the Union as the first state to grant women political equality and precipitated a Congressional battle that was sharper than any had been since the Civil War settled the issue of free versus slave states. Although it took several months, Wyoming, the first to grant universal suffrage, finally achieved statehood in July 1890.

⁵⁴² Garrison had predicted this would happen more than a half a century earlier, when he cautioned abolitionists to avoid political parties and make abolition their highest priority.

C. NAWSA

By 1890 it was apparent that the factors that caused the Woman's Rights movement to split into the NWSA and the AWSA were no longer of primary importance and the two groups merged into the National American Woman Suffrage Association (NAWSA) with Elizabeth Cady Stanton⁵⁴³ as its first president. The new organization, however, retained the conservative character of AWSA. As members became more affluent, the movement achieved greater prestige and influence and a new generation of leaders, who did not have the same broad social views as their predecessors,⁵⁴⁴ developed.

1. State Level Enfranchisement

NAWSA continued the work of trying to amend state constitutions to give women the vote but the results were not promising. Between 1870 and 1910, four hundred eighty campaigns were conducted in thirty-three states just to get the issue in front of the voters, plus seventeen actual votes of which two were successful: Colorado and Idaho.

The victory in Colorado in 1893 was important because it was the first state where men went to the polls and gave women the vote. The Idaho campaign in 1896 was significant because it was the first time that suffrage work was organized on a precinct

⁵⁴³ Although she remained president of NAWSA until 1892, Stanton's active leadership had come to an end. Her interests were focused on the divorce question and on an educated, rather than a universal, suffrage. See Flexner, *Century of Struggle*, pp. 222-8.

⁵⁴⁴ Elizabeth Cady Stanton and Susan B. Anthony were radical, unorthodox, and aggressive, and they worked for all women who needed help no matter what the reason. Anthony retained her gift of sympathy for women of any class to the very end of her life. This level of rapport and sympathy would never be attributed to the leaders who came after Stanton and Anthony. See Flexner, *Century of Struggle*, Chapter XVI.

basis, an organizational technique that would be the determining factor twenty-one years later in the most bitterly contested battleground of all, New York.

D. Second Generation of Woman's Rights Leaders

Before Susan B. Anthony stepped down as NAWSA president in 1900, she found two capable women to succeed her: Carrie Chapman Catt and Anna Howard Shaw. Catt was both an able speaker and a very capable organizer and the suffrage movement desperately needed her talents. Shaw, both minister and physician, was a gifted speaker who had worked with impoverished women in the Boston slums and understood that they needed laws to protect them and that some of those laws could only be made and enforced by women.

The movement needed an organizer and a leader free to devote all her attention to the cause, and the obvious choice was Carrie Chapman Catt. In her four years as president of NAWSA, Catt worked to introduce methods and structure into a rather haphazard organization, including "definite plans of work for local groups; state headquarters; study courses in political science and economics; a manual of organization; a consistent membership system; and soundly based national association finances."⁵⁴⁵ In 1904 Anna Howard Shaw succeeded Catt as NAWSA president and held the position for eleven years. Although she was devoted to the cause, Shaw was not the administrator that Catt had been and little was accomplished in the first decade of the twentieth century.

⁵⁴⁵ Flexner, *Century of Struggle*, p. 245.

1. State Level Suffrage Action

There were signs of life in the states, however, and the first sign came in New York, home of the two most dynamic women in the movement, Mrs. Catt and Harriet Stanton Blatch, the daughter of Elizabeth Cady Stanton. Blatch, returning to the United States after living for twenty years in England where she had been active in the British woman's rights movement, found the suffrage movement in a rut, boring its supporters, repelling its opponents, and totally lacking in political knowledge. She started her own organization, the Equality League of Self-Supporting Women.

The League broke new ground with the first open-air meetings in thirty years, by setting up card files of members by political districts, by conducting meetings at the gates of industrial plants to mobilize labor sentiment against recalcitrant members of the legislature, by actively campaigning against assemblymen who were opposed to suffrage, and by fighting in Albany for the right of women to serve as poll-watchers on election day. Blatch and her organization also initiated the parades that became so successful a form of suffrage agitation.

Women in other states began to try new forms of activity. In Massachusetts, four women undertook a trolley tour of the state, speaking in every small town along the way. In Illinois, similar tours were undertaken by automobile. In Maryland six hundred women journeyed to the state capital at Annapolis to demand the vote. New suffrage groups began to proliferate and this was a sure sign that the older ones were too static and restrictive.

New life may have emerged in the east but the first victories came in the west. In Washington Mrs. Emma DeVoe, who had received her organizational training from Catt,

ran a quiet but meticulously thorough campaign, with few suffrage meetings and no parades, but plenty of suffrage speakers at Grange, labor union, and church gatherings. Suffrage won in November 1910.

In California the suffrage organization focused on the essential small town vote,⁵⁴⁶ bypassed the big cities until the last week of the campaign, and watched the tally and the vaults to prevent tampering. The woman suffrage amendment won in California in 1911, with the margin of victory an average of one vote for every precinct in the state.

Six referendum campaigns were waged in 1912, in Arizona, Kansas, Oregon, Michigan, Ohio, and Wisconsin. Suffrage won in Arizona, Kansas, and Oregon, but in Michigan the brewers stole the pro-suffrage election. In Ohio and Wisconsin the liquor interests were too strong and the women too weak to require any blatant fraud and suffrage was defeated by a large margin. In Alaska, the first act of the legislature after territorial status was established was to enact suffrage. In Illinois, women received limited suffrage in presidential elections through action of the state legislature, the first limited victory for woman suffrage east of the Mississippi.

With the three victories in 1912 women had full suffrage in nine states with a total of forty-five electoral votes but the victories in Washington and California had aroused opposition that would grow in proportion to the political importance of the state. The level of effort to mount a state referendum campaign was staggering and the more politically important the state the lower would be the probability of victory. The state-by-state method route did not seem to be the best method of achieving woman suffrage so the suffragists turned their attention to Washington, D.C.

⁵⁴⁶ The small town vote was essential because the liquor interests would buy the big cities.

E. Rekindling Interest in the Federal Amendment

The interest in the federal amendment was at an all-time low. There had been no Senate debate since 1887 and the bill had not been reported out of committee since 1896. Alice Paul,⁵⁴⁷ a young American Quaker social worker who had served her suffrage apprenticeship with the militant wing of the British suffrage movement, and Lucy Burns, another American who worked with the British militants, went to Washington as the Congressional Committee of NAWSA to work for the passage of the Anthony Amendment. Paul and Burns gathered a small group of women and began to develop a spectacular campaign to tap the reservoir of interest in the amendment that they had detected in Washington. They organized a parade and scheduled it for the day before Woodrow Wilson's inauguration when the city would be filled with visitors from all over the country. Paul had a permit for the parade but received no practical help when a near riot broke out. Public opinion was outraged, the Chief of Police lost his job, the suffragists received enormous publicity, and the campaign picked up momentum.

Paul and Burns formed a national association, the Congressional Union, in 1913 for the purpose of working for passage of the federal suffrage amendment, moved across the country and organized in every one of the forty-eight states. They sent varied delegations of working women, professional women, college women, and western voting women to President Wilson, organized a petition drive, quickly gathered half a million signatures, and marched to the Capitol to present it to the President. Every activity was aimed at bringing the woman suffrage amendment out on the floor of Congress and in

⁵⁴⁷ For additional information on Alice Paul, Lucy Burns, and the Congressional Union, see Flexner, *Century of Struggle*, pp. 272-86.

this the Congressional Union succeeded, but on March 19, 1914 the woman suffrage amendment was defeated in the Senate and the following January 12, 1915, the amendment was defeated in the House. However, the woman suffrage amendment, dormant for a decade and a half, was once more a live issue in Congress, due to the work of the Congressional Union.

V. **Carrie Chapman Catt**

When Anna Howard Shaw retired as president of NAWSA, Carrie Chapman Catt⁵⁴⁸ was drafted to resume the presidency and she was too committed to the cause of suffrage and too stalwart a fighter to refuse the summons from the NAWSA convention. She was given carte blanche in regard to her Executive Board. Her assumption of the presidency that she had laid aside twelve years earlier⁵⁴⁹ marked a significant turning point for NAWSA. A profound change happened almost overnight and the women in the state associations began to receive precise imaginative directives regarding policy and program. Renewed activity in Washington, conferences between state and national leaders, training for organizers, fund-raising ideas, and real planning all signaled the promise of a new era in the suffrage movement.

Catt was able to promise and accomplish as much as she did because she selected a working board whose members were women of independent means with the ability and willingness to work single-mindedly on suffrage. These requirements would be

⁵⁴⁸ For information on Carrie Chapman Catt and the final years of the struggle to enfranchise women, see Flexner, *Century of Struggle*, Chapters XX-XXIII; Carrie Chapman Catt and Nettie Rogers Shuler, *Woman Suffrage: The Inner Story of the Suffrage Movement* (Seattle, WA: University of Washington Press, 1923), Chapters XVI-XX.

⁵⁴⁹ In 1904 Mrs. Catt resigned the presidency because of her husband's ill health and her growing interest in the international suffrage movement.

mandatory for the next five years. Catt's board was not designed for socially representative leadership but to give her an experienced staff who measured up to any demands made on them and it was one of the reasons that American women finally achieved suffrage. Amateur reformers were giving way to professional organizers.

Catt's unique contribution to the cause was to recognize that the issue was a political issue that could only be resolved by political action. She conceived a plan such that each disparate group could play a constructive part in achieving the goal and she executed the plan with her handpicked Executive Board.

A. The Strategic Plan

The first step in Mrs. Catt's strategic plan was to win the support of President Wilson, something that could be accomplished over time, as long as the suffragists did not personally antagonize him or challenge him on the issue. Hand-in-hand with presidential support was the effort of making suffrage as important a political issue as the many others on the agenda and war was an immediate issue as were innumerable domestic problems.

NAWSA sent delegations to President Wilson, educating him on the real difficulties in trying to achieve suffrage by the state route in the face of such political realities as stealing the Michigan vote in 1912, the opposition of the corrupt political machines in Ohio, Wisconsin, and New York, and the unlikelihood of piercing the armor of the solid South. Catt presented him with verified reports of election fraud in Michigan, Nebraska, and Iowa, argued that states' rights could hardly be considered ignored by an amendment that required three-fourths of the states to ratify it, and, above all, kept communication between NAWSA and the White House open.

Mrs. Catt and the NAWSA Board entered into a compact with more than thirty-six state organizations that were committed not only to working for the federal amendment but also to living up to their commitment. She used military thinking and the terminology of strategy, tactics, and operational details in developing and laying out her plan. Each state organization was an army, disciplined and obedient to its state officers who in turn would be obedient to the national officers. The strategic goal was the passage of the federal amendment in the December term of the 1920 Congress and tactical objectives included winning a few more states, selecting one southern state and working there to break the stranglehold of the anti-suffrage force, and breaking the deadlock in the six solidly anti-suffrage states in the East. Success would depend on their ability to “elevate [the fight] to the position of a crusade for human freedom.”⁵⁵⁰

When America entered World War I, NAWSA offered its services to the administration but did not abandon suffrage work⁵⁵¹ for war work. The women needed political standing and to some extent their ability to be successful would depend on their participation in the national war effort. Mrs. Catt, who was a realist, understood this and the suffrage cause made some gains.

On September 15, 1917 the Senate Committee on Woman Suffrage issued a favorable report on the measure and a House Committee on Woman Suffrage was finally appointed on September 24. The House set January 10, 1918 as the day to vote on the amendment. The states were also beginning to move. The North Dakota state legislature

⁵⁵⁰ Flexner, *Century of Struggle*, p. 292.

⁵⁵¹ During the Civil War all woman’s rights and suffrage activity ceased while the women focused on the war effort.

emulated Illinois and gave women presidential suffrage in January 1917 followed quickly by Ohio, Indiana, Rhode Island, Nebraska, and Michigan. The Arkansas legislature gave women the primary vote on March 6, thus creating the first breach in Southern opposition to suffrage. Although a Maine referendum was defeated in September, New York finally granted suffrage when Tammany Hall, the powerful Democratic machine, did not oppose the measure.

The special war session of Congress considered only war measures but when the regular session convened on December 3, 1917 it was free once again to discuss other measures. Woman suffrage was a high priority and NAWSA served notice that its patience was exhausted. If Congress did not act on the amendment before the next congressional election, NAWSA would enter into a sufficient number of senatorial and congressional elections to effect enough of a change in both houses to insure its passage.

President Wilson declared in favor of the Anthony Amendment, an indication that he was committed to leading the Democratic Party in support of it. The following day, January 10, 1918 the House voted and, though the vote was painfully close, the bill passed with exactly the two-thirds majority needed to pass a constitutional amendment, 274 to 136.⁵⁵²

⁵⁵² Four supporters of the amendment left sickbeds to participate in the vote and one left his wife's deathbed to attend the roll call then returned home for her funeral. The bulk of the votes against passage came from the southern states and the industrial states of Massachusetts, Pennsylvania, New Jersey, and Ohio. The Democrats were almost evenly divided with 104 in favor and 102 against, but the Republicans were solidly in favor of suffrage, with 165 for and only 33 against. See Flexner, *Century of Struggle*, pp. 301-3.

B. Formidable Opposition

It had been fifty years since the first state suffrage referendum in Kansas but overt opposition to woman suffrage continued to grow, harden, and become more active and more articulate. The interests that fought suffrage varied from one part of the nation to another.

In the South the great fear was the Negro vote and Southerners were reluctant to call attention to anything that addressed the rights of suffrage. In the Midwest, opposition came from the brewing and liquor interests who feared a resurgence of activity in the temperance movement. The political machines opposed suffrage because they were afraid they would not be able to control women voters who did not seem to be susceptible to bribery, were militant about effecting reforms in regard to working women and child labor, and committed to cleaning up politics. The Catholic Church did not explicitly support or oppose woman suffrage but Cardinal Gibbons actively supported anti-suffrage and anti-suffrage leaflets were provided to Catholic voters in Massachusetts. Comparable tactics were used in other Catholic enclaves around the country. Big business was solidly aligned against woman suffrage because they feared that women would use the vote to improve the conditions of working women and to make child labor illegal. Some opposition came from southern women who were committed to suffrage, but by state referendum only, as a means of insuring white supremacy.

VI. The End of the Struggle

After the House passed the woman suffrage amendment on January 10, 1918, it took another year and a half and the election of a new Congress to get the amendment passed in the Senate and then another fourteen months for ratification by thirty-six states.

Mrs. Catt's winning plan for advancing the cause of suffrage was showing some impressive results but more work needed to be done. In early 1918 there were eleven full suffrage states but only one east of the Mississippi River. The only breach in the solidly opposed South was the granting of primary suffrage in Arkansas. Five states granted women suffrage in presidential elections, all but one in the Midwest, and three states had canceled action to grant presidential suffrage.

Although when the Senate voted on the suffrage amendment on October 1, 1918, the bill was defeated by two votes, the vote cleared the air. The women knew what they had to do and moved swiftly to fulfill their 1917 pledge to remove certain Senators who opposed woman suffrage. Four Senators up for reelection in four weeks were marked for defeat and two of them, although well-entrenched machine politicians, were defeated while the other two lost their huge majorities and were just barely reelected. In the same election, three states granted suffrage by referendum and the fourth, Louisiana, lost by only a few thousand votes, an impressive showing in a southern state.

The Sixty-Fifth Congress convened in special session on May 20, 1919 and President Wilson sent a message to both House and Senate recommending passage of the amendment. The House acted the same day and once again passed the amendment, this time by a vote of 304 to 89, 42 more than the required two-thirds majority. The Senate debate dragged on for two days, but on June 3 the roll was called and the woman suffrage amendment passed by a vote of 66 to 30.

A. Ratification

Initial response was positive. Wisconsin had the honor of being first to file its formal ratification resolution with the Secretary of State and Illinois was a close second.

Michigan was the first to call a special session of its legislature and it was third to ratify. All three acted on June 10 and New York and Kansas followed on June 16.

It seemed that the states that had first granted women full suffrage were slow in ratifying. Montana, the first western state to act, ratified on August 2. Utah was the thirteenth to ratify, on September 30. California acted on November 1, and Colorado delayed ratification until December 12. Wyoming, the first state to grant women full suffrage, did not ratify until January 26, 1920, the twenty-seventh state to act. Washington was the thirty-fifth to ratify, on March 22, 1920.

There had been some breaches in the solid Southern opposition to woman suffrage. Texas was the first southern state to ratify, the ninth in the nation. Kentucky, one of the border states, ratified on January 6, 1920. Nine of the southern states⁵⁵³ never ratified the amendment. Tennessee finally became the thirty-sixth state to ratify and the Secretary of State signed the proclamation certifying the final adoption of the Nineteenth Amendment on August 26, 1920, enfranchising twenty-six million women of voting age.

In 1920, the Nineteenth Amendment was ratified⁵⁵⁴ and all adult women had the right to vote in the presidential election in November. NAWSA was transformed into the League of Women Voters, a non-partisan organization for the purpose of educating women on issues and candidates. It had taken seventy-two years of struggle to achieve woman suffrage and along the way some other rights were gained as well. Women could be educated and enter the learned professions, own property and retain their earnings,

⁵⁵³ The nine states were Virginia, Maryland, North Carolina, South Carolina, Georgia, Alabama, Louisiana, Mississippi, and Florida.

⁵⁵⁴ The last threat to woman suffrage was not defeated until February 1922 when the United States Supreme Court handed down the second of two decisions upholding the Nineteenth Amendment. See Flexner, *Century of Struggle*, p. 337.

speak in public and sign a contract, and work long hours both outside the home as well as inside the home.

VII. **Why Examine Woman's Rights and Suffrage?**

The struggle to gain for women the same civil, legal, political, and property rights enjoyed by men, including the right to vote, is an important part of American history and as such should be studied and understood. It is important to realize that the rights that are so much taken for granted did not always exist, either in law or in fact, and that the people who perceived the injustice of the denial of these rights to half the American people took action to secure justice for all. American history is filled with examples of the people recognizing injustice and taking action to right the wrong.

In the eighteenth century, the American people recognized injustice in the tyranny of taxation without representation and took action, the Revolutionary War for Independence, to end it. In the nineteenth century, the American people recognized injustice in the institution of slavery and again took action, in a social reform movement to abolish slavery, to rectify the injustice. By mid-nineteenth century the American people recognized the injustice of denying civil, legal, political, and property rights to half the population and began the work, a second social reform movement for Woman's Rights and Suffrage, that would eventually grant civil, legal, political, and property rights to women. The work of social reform did not end with the ratification of the Nineteenth Amendment but continued throughout the twentieth century and into the present time.⁵⁵⁵

⁵⁵⁵ It is beyond the scope of this dissertation to introduce all the social reform movements that have been launched in the United States, but some examples are the labor movement, the Civil Rights movement, the Senior movement, the Farm Workers movement, and the very recent Immigration movement. Of these, the Civil Rights movement is probably the best known because it occurred fairly recently and is an example of

If the American people of the past could recognize injustice and take action to change the course of history, then the American people of the present and future should also be able to recognize injustice and take action to change the course of history. The abolitionists were pioneers in fomenting reform through a social reform movement, and the woman's rights activists, following the trail blazed by the abolitionists and cutting new paths through the wilderness when necessary, were also successful in achieving reform through a social reform movement. Contemporary reformers can learn from the successes of the past to precipitate and direct social reform movements of the future.

VIII. Woman's Rights and Suffrage as a Social Reform Movement

A social reform movement⁵⁵⁶ is a form of social protest that enables ordinary people to make collective claims on authorities, public or private, and achieve objectives without resorting to the violence of a bloody revolution. It is a distinctive way of pursuing public politics that includes sustained, organized public campaigns, a repertoire of political practices, and public representations of worthiness, unity, numbers, and commitment on the part of reformers, their constituents, and their cause. Social movements are an invented and distinctive form of contentious politics, contentious because they involve the collective making of claims that conflict with the interests of others and politics because governments are almost always involved, usually as the object of the claim. When authorities are unable or unwilling to act to redress injustice, people, ordinary citizens, form social movements to effect necessary reforms.

a second social reform movement associated with slavery. The Civil Rights movement gained in fact what the emancipated slaves and their descendants had been granted in law a century earlier.

⁵⁵⁶ For a more complete explication of social reform movements, see Chapter Five of this dissertation. See also Charles Tilly, *Social Movements, 1768-2004* (Boulder, CO: Paradigm Publishers, 2004), Chapter 1.

A social movement develops from and consists of a synthesis of three elements: a campaign, a repertoire of political action, and a continuing public display of worthiness, unity, numbers, and commitment (WUNC). A *campaign* is a sustained, organized public effort that makes claims on target authorities and extends beyond a single event and always includes at least the group making a claim (the proponents of social reform), the object of the claim (usually, but not always, the government), and the public. The interaction among these entities constitutes a social movement.

The *repertoire* consists of a number of forms of political action, all intended to get the message out in front of the public, to arouse more individuals to support the movement, and to persuade the objects of the claim to take action to resolve the issue. The integration of the political repertoire into a sustained campaign is integral to a social movement and differentiates it from other varieties of politics.

Continuing public displays of *WUNC* (worthiness, unity, numbers, and commitment) keep the issue and the message in front of the public in a form they can recognize and relate to.

The integration of these elements — campaign, repertoire, public displays of WUNC (worthiness, unity, numbers, and commitment) — and sustainable collective action separate a social movement from other forms of contentious action. Social movements maintain their challenge of the status quo regardless of fierce opposition and even violence. This ability to interact with powerful opponents and at the same time maintain identity and sustain collective action is the mark of a social movement.

A. Hallmarks of Social Reform Movements

Thus, the hallmarks of a social reform movement include ordinary people protesting social injustice, making claims on authorities, and achieving objectives without violent revolution. In pursuing reform, social reform movements utilize sustained public campaigns, a variety of political practices, and continuing displays of worthiness, unity, numbers, and commitment. Social reform movements make claims that conflict with the interests of other parties, resolve their claims through the political process, sustain their claims over a long period of time, and maintain their challenge of the status quo regardless of the extent of opposition. How then does Woman's Rights and Suffrage match these characteristics of social reform?

B. Social Reform Attributes and Woman's Rights and Suffrage

The work that developed into Woman's Rights and Suffrage was born in and grew out of the abolition movement as women who worked long and hard to free the slaves and secure equal rights for them realized that in many respects they were as much in bondage as were the slaves. The inalienable rights enumerated in the Declaration of Independence were not granted to them and they enjoyed no civil, legal, political, or property rights.

As women became more aware of the totality of the injustice perpetrated against them, they began to speak out and to take action to redress the injustice. Thus, like the work to abolish slavery, the effort to achieve equal rights and suffrage for women began with a small group of ordinary women⁵⁵⁷ who protested the status quo and began the

⁵⁵⁷ Although women began the effort to secure equal rights and suffrage and were active throughout the long years of hard work, men were also active supporters of equal rights and suffrage for women. Some

work to change it. This group of ordinary people made their claims, that women were equal to men and should be granted full and equal rights, civil, legal, property, and political, including the right to vote, against government and patriarchal society and achieved their objectives without resorting to the violence of a bloody revolution.

The social reformers who came to be known as woman's rights activists or suffragists sustained their campaign for equal rights and suffrage for women for a period of more than seventy years.⁵⁵⁸ The campaign to secure equal rights and suffrage for women was very long, arduous, and public, with annual conventions plus regular meetings and rallies, and lectures delivered in meeting halls, churches, and public squares. The reformers conducted petition drives and letter-writing campaigns, wrote and distributed tracts and pamphlets, and eventually formed organizations at local, state, and national levels to organize the efforts and further the work of equal rights and suffrage for women. When the focus of the reform work shifted to suffrage, the women traveled from state to state to conduct political campaigns to get the issue of suffrage onto the ballot. The reformers demonstrated worthiness, unity, numbers, and commitment to the cause by continuing to work and agitate for equal rights and suffrage for women in spite of hostile and even violent opposition, undeterred by the harsh, dangerous, and

were introduced to the work by their wives, mothers, and daughters, but others came to accept the work of Woman's Rights and Suffrage without a nudge from a female relative. All ardently believed that the rights enumerated in the Declaration of Independence and promoted as ideals in the Preamble to the Constitution, including the right to vote, applied to women as well as to men.

⁵⁵⁸ The seventy years refers to the span from the Seneca Falls convention in 1848 to the ratification of the Nineteenth Amendment in 1920. Women began to achieve some rights prior to Seneca Falls and achieved some other rights during the long battle to secure suffrage. The focus is on suffrage because it was in the Resolutions at the Seneca Falls convention that suffrage — the right to the elective franchise — was first mentioned as a formal objective of the nascent Woman's Rights and Suffrage movement.

primitive conditions they encountered while traveling to promote the cause, and despite persistent efforts to silence them and prevent them from achieving their objectives.

The reformers claimed that the subjugation of women, denying them equal rights including civil, legal, political, and property rights and the right to vote, was wrong, unjust, and in violation of the promises of the Declaration of Independence and the ideals included in the Preamble to the Constitution, and their claims conflicted with the interests of the traditional patriarchal society, the government, special interest groups, and much of the public. Unlike the abolitionists, the woman's rights activists and suffragists began to work through the political process almost immediately, sending petitions for the redress of specific grievances to state legislatures in particular. The reformers continued to challenge the status quo of the subjugation of and denial of rights to women despite fierce opposition and persisted until women gained equal civil, legal, political, and property rights, including the right to vote.

Thus, in regard to overall high-level criteria, Woman's Rights and Suffrage measures up well to a social reform movement. It did what a social reform movement is intended to do, that is, achieved social reform through contentious politics without violent revolution. Therefore, since Woman's Rights and Suffrage was a social reform movement, the second such movement in American history, what lessons can be learned from it? These lessons can be applied to future efforts at social reform such as a movement to effect comprehensive reform of the American health care system.

IX. Lessons to be Learned from Woman's Rights and Suffrage as a Social Reform Movement

Like abolition, Woman's Rights and Suffrage was a social reform movement, not only in the respect that it accomplished social reform but also in how it achieved that

change. However, Woman's Rights and Suffrage developed somewhat differently than abolition. With abolition, liberty, the right to be free and recognized as human beings, preceded all other rights. Therefore, the abolitionists focused solely on emancipation with equal rights for the newly emancipated. With Woman's Rights and Suffrage, no such dependency existed and therefore the struggle to gain rights for women proceeded asynchronously and in parallel. Thus, for example, the fight for the right to be educated could be waged at the same time as the fight for the right to own property because one did not precede the other. As a result, the early days of the Woman's Rights and Suffrage movement appeared to lack the coherence and cohesiveness associated with the abolition movement, yet all the reformers were working toward the same ultimate goal, that is, equal rights for women. By examining the work of the Woman's Rights and Suffrage movement, valuable lessons can be gained, lessons that might be somewhat different than those learned from abolition but valuable all the same, lessons that can be applied to future efforts at social reform. This section will examine the Woman's Rights and Suffrage movement to determine what lessons can be learned. However, it must be noted that the most important lesson of all is to begin the work of reform. Once the work has begun, other lessons can then be drawn.

A. Leadership

The first lesson to be learned from Woman's Rights and Suffrage is the importance of leadership,⁵⁵⁹ at multiple levels and with different talents and styles of leading. Elizabeth Cady Stanton, who with a small group of like-minded women took the

⁵⁵⁹ The emergence of a leader marked the beginning of the social reform movement. The idea of the need for social reform had existed for many years.

action that began the Woman's Rights and Suffrage movement, was a visionary leader who understood that women had to gain the right to vote or they would never gain the equal rights they sought. Susan B. Anthony was another leader who had great political acumen and the phenomenal organizational skills to put ideas into practice and accomplish the work that needed to be done. Carrie Chapman Catt, leader of the movement when suffrage was granted, was an organizer with superb administrative skills who recognized that the issue was a political issue that could only be resolved by political action. Stanton, Anthony, and Catt were all national leaders of Woman's Rights and Suffrage and gave focus and direction to the movement. However, leadership at the grassroots level was also essential to the success of Woman's Rights and Suffrage.

Because different rights were being agitated in different places at the same time, the most important levels of leadership were at the grassroots local and state levels and the names of these leaders have not been written into the history of Woman's Rights and Suffrage. However, because so much work was organized and accomplished, it can be inferred that these leaders were there, were dedicated, and were ultimately successful and thus made an enormous if anonymous contribution to the drive to achieve equal rights for women. Thus, leadership at every level, with varying sets of talents, skills, and leadership styles, was critical to the success of Woman's Rights and Suffrage and is an important lesson for reformers of the future.

B. Structure and Organization

A second valuable lesson to be drawn from the Woman's Rights and Suffrage movement is the importance of structure and organization for this is an area in which Woman's Rights and Suffrage exemplifies what not to do. A structured organization is

important for sharing information and experiences, for providing overall direction, and for minimizing or eliminating duplicated efforts. However, activists for Woman's Rights and Suffrage had no central organization for more than a quarter of a century because the women were afraid that an organization would be cumbersome and restrict individual effort and many learning experiences were either lost or duplicated. The right leader must also be in place to direct the organization.

Thus the real lesson is not only that both structure and organization are necessary for success but also that leadership capable of using the resources of the organization to optimum advantage must be in place.⁵⁶⁰

C. The Issue, the Message, and Identity

The composite of the issue, the message, and identity provide a third important lesson to be learned from the Woman's Rights and Suffrage movement. The issue, that women were being unjustly deprived of their civil, legal, political, and property rights, was formulated early in the movement and remained essentially unchanged. The message, however, varied over time and in accordance with whatever right was being agitated.⁵⁶¹ In the latter days of the movement, when the focus shifted to suffrage, the issue and message became more closely intertwined because by that time equal rights for women meant suffrage.

⁵⁶⁰ The real strength of the Woman's Rights and Suffrage movement, as would be true with any social reform movement, was its people, the dedicated women and men who believed in the cause and did the work to gain rights for women. The combination of leadership, structure, and dedicated people will be just as critical in a contemporary social reform movement as it has been in the past.

⁵⁶¹ For some activists the message was the right to be educated, for others the right to speak in public and for still others, the message concerned or the right to control earnings. The issue was the same, equal rights for women, but the message varied. When many rights had been gained and the focus was suffrage, both the issue and the message became simpler: equal rights for women meant suffrage.

Identity refers to the people on whose behalf social reform is advocated.⁵⁶² Woman's Rights and Suffrage advocated on behalf of all women who, by virtue of their gender, were a definite and easily identified group within the larger population. The larger population easily understood the identity of those on whose behalf social reform was advocated because everyone had some personal association with women as mothers, sisters, wives, and daughters.

D. Symbols

Symbols are closely allied to identity and constitute an important factor in any campaign to stir up interest in a new and possibly unpopular cause. The use of symbols is particularly crucial when the public does not readily recognize or relate to the identity of those on whose behalf the cause is being agitated. In Woman's Rights and Suffrage, however, women were visible to the public, a significant segment of the larger population, and thus were their own living symbols. Thus symbols are important and must be tailored to the needs of the cause being agitated.

E. Communications

A fifth important lesson, one related to both the composite of issue, message, and identity, and the symbols that depict the composite, is the importance of powerful communications. In the past, despite a complete lack of internet access, electronic mail, weblogs, twenty-four hour cable news networks, cellular phones, and instant messaging, small but extremely dedicated groups of people created social reform movements that

⁵⁶² Identity is important because it creates a bridge between the abstract idea of social reform and the concrete reality of the people who are suffering because of injustice. Thus, while it is important to identify specific individuals who are working for and/or benefiting from social reform, it is equally important to identify the whole group or class of beneficiaries, even if their individual names are not known. People — supporters and potential supporters — respond more readily to the concrete than to the abstract.

aroused public opinion sufficiently to overturn socioeconomic systems that had existed for millennia, first to abolish slavery and then to extend to women the rights they were denied by a patriarchal system.

The importance of communications is to use whatever form of communications⁵⁶³ is available to get the message of reform out to the public and to keep repeating the message until it arouses enough public opinion to accomplish the reform being sought.

X. Other Lessons to be Learned from Woman's Rights and Suffrage

Other lessons can be learned from the fact that the Woman's Rights and Suffrage activists sustained their public campaign, in the face of formidable opposition, for more than seventy years, from the repertoire of practices that the suffragists⁵⁶⁴ developed and refined, from their public displays of worthiness, unity, numbers, and commitment, and from their opposition.

A. Sustained Public Campaign

The seventy years of effort, from the Seneca Falls Convention in 1848 to the ratification of the Nineteenth Amendment in 1920, is one measure of the sustained nature of the campaign to gain civil, legal, political, and property rights, including the right to vote, for women.⁵⁶⁵ The fact that the suffragists inspired another generation of

⁵⁶³ Abolitionists had their own newspaper, *The Liberator*, to agitate for reform. The woman's rights activists did not have that luxury so they used every form of communication, both written and oral, to present and repeat their message of the need for reform.

⁵⁶⁴ The term 'suffragists' is shorthand for all the activists, women and men, who worked to gain civil, legal, political, and property rights, including the right to vote, for women.

⁵⁶⁵ So much time elapsed from the first declaration of the right to vote to the granting of that right that only one woman who participated in the Seneca Falls Convention, Charlotte Woodward, was still alive to vote for the President of the United States in 1920. See Flexner, *Century of Struggle*, pp. 75-6.

activists⁵⁶⁶ to continue the work of the Woman's Rights and Suffrage movement is another measure of the sustained nature of the campaign to gain civil, legal, political, and property rights, including the right to vote, for women.

B. Repertoire of Practices

The activists in the Woman's Rights and Suffrage movement built an impressive repertoire of political practices. Many of these practices were new and innovative at the time and some of these practices have since become standards. Very early in the struggle to gain equal rights for women, activists sent petitions to state legislatures asking for specific measures. Susan B. Anthony was the first to recognize that thousands of signatures were needed in order to gain legislative hearings and to organize the activists so that every county and large city would be canvassed.

Much later in the struggle for equal rights for women, when the focus was specifically suffrage, the Equality League of Self-Supporting Women, founded by Harriet Stanton Blatch, daughter of Elizabeth Cady Stanton, initiated several new forms of agitation including the parades that became a very successful form of suffrage agitation.⁵⁶⁷

The women in Idaho were the first to organize suffrage work on a precinct basis, a form of organization that became the standard in other states and would be the

⁵⁶⁶ The first activists in the Woman's Rights and Suffrage movement were second-generation abolitionists. Thus, the generation that inherited the mantle of reform from them were actually the third generation of American social reform activists.

⁵⁶⁷ The Equality League expanded the movement's repertoire by conducting open-air meetings, by setting up card files of members by political districts, by conducting meetings at the gates of industrial plants to mobilize labor sentiment against recalcitrant members of the legislature, by actively campaigning against assemblymen who were opposed to suffrage, and by fighting in Albany for the right of women to serve as poll-watchers on election day. See Flexner, *Century of Struggle*, pp. 257-61.

determining factor in winning suffrage in New York two decades later. In Washington, the fight for suffrage was conducted quietly, at the grassroots level, with suffrage speakers at Grange, labor union, and church gatherings. In California the campaign was also conducted at the grassroots level, in small town and village meetings and in parlor talks.

Many of the Woman's Rights and Suffrage practices have become standard procedure but they were new and innovative at the time and added immeasurably to the success of the movement.

C. Public Displays of Worthiness, Unity, Numbers, and Commitment (WUNC)

The Woman's Rights and Suffrage movement displayed worthiness, unity, numbers, and commitment (WUNC) by holding regular meetings and conventions that provided a forum for the exchange of ideas, demonstrated the growing strength of the movement, and attracted new adherents to the cause. Women who attended these meetings and conventions brought friends, neighbors, children and grandchildren with them to the gatherings.⁵⁶⁸

The women who gathered signatures for petitions demonstrated real commitment to the cause, defying husband or father to go out, knock on doors and ask for support for a cause that was unpopular and diametrically opposed to tradition. The women who traveled in support of the effort to gain equal rights for women also demonstrated courage and commitment facing harsh travel conditions, hostile environments, and primitive

⁵⁶⁸ This might have been because they had no one with whom to leave the children, but it also served to educate the next generation of reform activists.

living conditions. The ultimate success of these courageous women is a measure of their commitment to the cause of equal rights for women.

D. Opposition

Opposition to of Woman's Rights and Suffrage came, as expected, from the traditional patriarchal society and also from several special interest groups that had no direct connection with rights in general or woman's rights in particular.

One such special interest group was the liquor industry, a group that feared the complete prohibition of alcohol if women had the vote.⁵⁶⁹ The political machines were also opposed to suffrage because they feared they would not be able to control women voters.

Big business was a third group solidly opposed to woman suffrage although they worked covertly and behind-the-scenes. Nevertheless their influence was very real for big business feared that if women could vote, then reforms to improve the conditions of working women and to prevent child labor would be enacted.

Yet, in spite of powerful, well-organized, and well-financed opposition, the activists persisted in their fight and succeeded in gaining for women civil, legal, political, and property rights, including the right to vote.

E. Most Important Lesson

Yet, what is perhaps the most important lesson to be learned from Woman's Rights and Suffrage is the importance of flexibility, the ability to adjust to the exigencies of the cause being agitated. The two great social movements that have been examined,

⁵⁶⁹ Prohibition became law without any help from women voters.

Abolition and Woman's Rights and Suffrage, developed very differently because the needs of each were very different. With abolition, for example, the right to liberty had to be gained before any other right was meaningful and therefore the abolitionists focused on freedom, liberty — immediate emancipation — constantly throughout the fight to abolish slavery. This was not the case with Woman's Rights and Suffrage because no one right held precedence over the others. Thus, the fight to attain the right to be educated, for example, could be waged at the same time as the fight for the right to own property because there was no dependency between these rights. Thus, because a variety of rights were being agitated simultaneously and independently, many leaders emerged at local and other levels to direct the efforts of these 'movements-within-a-movement.'

When a sufficient number of rights had been gained to make enough women aware of the need for a voice in the political process and therefore the need for the vote, the focus of the Woman's Rights and Suffrage movement became more fixed on a single goal. Even then, however, the work of Woman's Rights and Suffrage was significantly different than that of abolition, although it was still an organized movement to achieve social reform. Woman's Rights and Suffrage conducted a multilateral campaign, with work proceeding at the state level simultaneously with the effort to gain the franchise by federal amendment. As each additional state granted suffrage, the argument to extend suffrage to all women through a federal amendment became more compelling.

Other characteristics of social reform movements were also changing. The vitally important work at the grassroots level continued to be done by dedicated volunteers, but the leadership began to move away from volunteers toward professional organizers.

XI. Applying Lessons Learned from Woman's Rights and Suffrage as a Social Reform Movement

In order to apply the lessons learned from Woman's Rights and Suffrage as a social reform movement, it is necessary first to begin the work. It is necessary to remember that grievances alone, no matter how articulate the speaker or how worthy the cause, will not precipitate a social reform movement to effect comprehensive reform. The birth of a social reform movement requires leadership, a program, and a sharp stimulus to focus attention on the work being started. Thus, as the work begins, leadership will emerge, either from the very first to recognize the need and begin the work, or from the early converts to the cause of reform. Leadership may come from a single individual, or from several individuals, who may or may not be like-minded, in different grassroots locations. However, for leadership to emerge and be effective, there must be something and someone to lead.

Very quickly a structure will begin to develop simply because most people are more comfortable with some level of structure than with chaos, and structure can work to further the cause. As structure develops, groups should make use of what they have learned in other situations to create an organization that will optimize the use of resources available to the cause. In contemporary American society, nearly everyone has some experience with organizational structure, whether from working in the business world or from dealing with government bureaucracy. This knowledge and these skills should be applied to creating an efficient organization for the social reform movement.

In defining the issue to be agitated and formulating the message to present the issue to the public, a future social reform movement should pay close attention to the work of the Woman's Rights and Suffrage movement and define the issue as radically as

possible but focus the message on intermediate goals and objectives. For Woman's Rights and Suffrage, the issue was defined as gaining for women civil, legal, political, and property rights, including the right to vote. The right to vote was the most radical factor of the issue, yet it was included as a right that must be gained for women from the very start of the movement. However, other rights could be and were gained for women prior to and separate from the right to vote and agitating these rights became the focus of the immediate message. Thus, the activists kept the ultimate goal in mind but worked steadily to achieve intermediate objectives. Elizabeth Cady Stanton, for example, understood from the very beginning of the movement that women would need the right to vote in order to attain any political influence and she never lost sight of that ultimate goal, yet she worked steadily to attain other objectives.

Stanton, as the radical abolitionists before her, understood that women had to demand equal and exact justice in order to get even partial redress. If they demanded anything less than justice, they would get little if anything. Thus, a contemporary reform movement should make its ultimate demands comprehensive and radical in order to ensure that even partial reform is accomplished. Then, having defined the issue and formulated the messages to deliver it to the public, contemporary reformers should stick to the issue until comprehensive reform is achieved. Even if contemporary reformers should disagree among themselves, it is essential to present a united front to the public, to potential supporters, and to opponents.

Contemporary reformers should establish some form of official communications, whether that form be a reform-sponsored newsletter or a direct link to some already existing form of communication. In this era of instantaneous communications, it is all

too easy for misinformation to be acquired by the media and passed along as fact. Therefore, reformers should establish some source of official information that will be available to all and ensure that the information source is always timely and accurate. Whatever form of communication is selected, it should be easily accessible, perhaps a hotline or a website. It is easier in the long run to provide accurate information than to put out the fires caused by misinformation.

Having begun, a contemporary social reform movement will have to be willing and able to sustain the campaign, possibly over a very long time, in the face of anything and everything, from public apathy to opposition hostility. As past social reform movements have demonstrated, reformers could even encounter violence. The repertoire of practices and public displays of worthiness, unity, numbers, and commitment will grow out of the sustained campaign. Like reformers of the past, contemporary social reformers will have to persevere.

XII. Conclusion

What was not achieved in the seven decades and what in general has not yet been achieved is equal pay and equal opportunity.⁵⁷⁰ Working conditions have improved, but sweatshops still exist and immigrants are still exploited as the main source of cheap labor. Some reform never happened, such as the Child Labor Amendment and the Equal Rights Amendment.⁵⁷¹ Admittedly, the reform wave loses its energy and reaction sets in and this may help to account for what was not achieved by Woman's Rights and

⁵⁷⁰ From forty-five years of experience in the business world, the writer of this dissertation can attest to the fact that neither equal pay nor equal opportunity has been achieved. The glass ceiling is only too real.

⁵⁷¹ Alice Paul of the National Woman's Party first proposed the Equal Rights Amendment (ERA) in 1920. The ERA is associated with the 1970s Women's Liberation movement, but in fact it originated in 1920.

Suffrage. However, it is possible that the movement leaders bypassed a golden opportunity to further the cause of reform.

The women who were so well organized and fought such brilliant campaigns to win suffrage were undoubtedly exhausted and ready to retire after the Nineteenth Amendment was passed, but this may have been a mistake. Women had become politically savvy, reluctantly and perhaps even unknowingly. Carrie Chapman Catt, for example, was not only a superb organizer and gifted leader; she was also a shrewd politician. The political arena and the voters, male and female, were certainly aware of the suffrage movement leaders, so they had what in contemporary terms would be called name recognition. They knew the issues and they knew how to get things done. Perhaps at least some of them should have entered politics and run for office. They might have kept reform alive and they most probably would have inspired and trained another generation of women reformers.

There was a comparable dilution of energy among the abolitionists after Congress had passed the Thirteenth Amendment abolishing slavery. It took nearly a century and another social reform movement — Civil Rights — to put teeth into some of the laws that extended equal rights to the emancipated slaves and their descendants. The Woman's Rights movement resurrected as Women's Liberation shortly after Civil Rights had become a national watchword but appears to be dormant at this time.

Much work remains to be done, for injustice and unfairness have not been eradicated. Since this is so, there is still a place for social reform in contemporary America. Perhaps it is time for American activists to work for justice by launching a twenty-first century social movement to reform the American health care system.

Chapter Eight

Health Care as a Social Reform Movement

I. Introduction

A. Recap of Parts One and Two

In developing the thesis of this dissertation, that a social reform movement is in order and might be necessary to effect reform of the American health care system, several foci have been considered. Part One, Justice, focused on why reform is necessary and supported the idea that Americans have a moral right to health care, a right that is being violated because the American health care system as currently structured does not guarantee access for all. Reform is necessary because justice demands that a rights violation be redressed. In contemporary American society, this moral right to health care must be transformed into a legal right in order to be effectively recognized and honored.

Part Two, Policy, focused on past efforts to create the policy and enact the legislation that would transform the moral right to health care into a legal right to health care for all Americans. All attempts except one, Medicare, failed.⁵⁷² Medicare, however, guarantees access to health care for only a subset of the population. Since the

⁵⁷² The current (2009-2010) effort to reform the American health care system has been successful in enacting legislation, an important first step on the way to comprehensive reform. However, this does not mitigate the need for continuing grassroots activism to complete the work. Considering the level of effort being expended to attempt to repeal the new legislation, a social reform movement may be more necessary now than at any time in the past.

government is unable or unwilling to act to redress the injustice of the current health care system, then the citizens must act to accomplish reform.

B. Recap of Part Three

Part Three of this dissertation addresses reform by means of a social reform movement, a nonviolent alternative to violent revolution, and examines two previous American social reform movements, the abolition of slavery and woman's rights and suffrage. At this point, having reviewed social reform movements as a form of social protest that enables ordinary people to make collective claims on authorities and achieve objectives without resorting to bloody revolution, and having considered how the abolition and woman's rights and suffrage movements accomplished their goals and effected comprehensive social reform, it is now appropriate, in this last chapter, to examine more closely the potential for reform of the American health care system by means of a contemporary social movement.

C. Overview of Chapter Eight

The thesis of this dissertation is that a social reform movement is called for and might be necessary in order to accomplish comprehensive reform of the American health care system. Chapter Eight will develop the thesis by clarifying the work to be done by American social reform activists in beginning and sustaining a health care reform social movement and by addressing implications for related fields such as health care ethics. Chapter Eight will begin by examining the possibility of fomenting a social reform movement for the purpose of accomplishing comprehensive reform of the American health care system and conclude with a brief summary of the major points of the dissertation and how each point helped to develop the thesis.

This examination will begin with a brief overview of social reform movements, then inquire into why a social movement for health care reform might be appropriate and explore how such a social movement might begin, develop, and work toward major socioeconomic change. Following this will be a discussion of what contemporary health care reform activists might learn from the past success of previous social reform movements, specifically Abolition and Woman's Rights and Suffrage, and also from the success of the opposition that has defeated previous attempts at health care reform. After this will be a brief review of the status of American health care reform, work in progress and work to be done. Chapter Eight will conclude with a discussion of some of the implications of health care reform for related fields such as health care ethics and a recap of the major points of the dissertation and how each point was supported by the dissertation.

II. Social Reform Movements: A Brief Overview

A. Form of Social Protest

A Social Reform Movement is a form of social protest that enables ordinary people to make collective claims on authorities and achieve objectives without resorting to violent bloody revolution. It is a relatively new form of social protest, having emerged in the late eighteenth and early nineteenth century as a distinctive way of pursuing public politics, and it evolved into modern social movements with sustained, organized public campaigns, repertoires of political practices, and public representations of worthiness, unity, numbers, and commitment. Social movements are an invented and distinctive form of contentious politics, contentious because they involve the collective making of claims that, if realized, would conflict with the interests of other parties, and politics

because governments are almost always involved, usually as the object of the claim. When authorities are unwilling or unable to act to redress injustice, ordinary citizens began to form social movements to effect necessary reforms.

Social movements all involve ordinary people who make collective demands for the redress of injustice. These movements occur in many situations against great odds and are frequently successful. Social movements are all bottom-up approaches to resolving injustice, starting at the grassroots level with ordinary people and spreading in ever-widening circles to attract more ordinary people. As these movements spread wide at the grassroots level, they also percolate up the social ladder to reach the elites, the influential, and the authorities. Social movements always demand action. Eventually, as a social movement grows, it will attract a critical mass of ordinary people, thus making its demands more acceptable in a democratic republic, and in this way accomplish reform without violence.

B. Synthesis of Three Elements

A social movement develops from and consists of a synthesis of three elements: a campaign, a repertoire of political action, and a continuing public display of worthiness, unity, numbers, and commitment (WUNC). A *campaign* is a sustained, organized public effort that makes collective claims on target authorities. A social movement *repertoire* consists of a number of forms of political action, all intended to get the message of reform out to the public and to persuade the authorities to take action to resolve the issue. Continuing public displays of *WUNC* (worthiness, unity, numbers, and commitment) are designed to draw public attention to the cause, to the oppressed on whose behalf the cause is being agitated, and to the activists who are pursuing the redress of injustice.

The integration of the three elements (*campaign, repertoire, WUNC*) and sustainable collective action separate a social movement from other forms of contentious action. Social movements must be able to maintain their challenge of the status quo in the face of formidable opposition. This ability to interact with powerful opponents while maintaining identity and sustaining collective action is the mark of a social movement.

A social movement will stir up public opinion and cause turbulence and unrest among the apathetic, the uninformed, the passive, the opinion groups, the elites, and especially the opposition. The higher the degree of turbulence, the more the elites will demand that authorities do something to quiet the unrest and policy makers will eventually respond to these demands. Actions that begin in the streets are, and must be, resolved in the halls of government.

It is important to understand that the opponents of any type of social reform almost certainly are and will be powerful and very well organized, with access to almost unlimited funding. Any social movement, most probably with little power and limited funding, must be able to sustain collective action in interacting with these powerful opponents and persuade others that their cause is worthy of support. Considering the power of the organized coalition of stakeholders opposed to health care reform and the magnitude of the effort that will have to be expended in order to overcome this opposition, it is relevant to ask why it is appropriate to launch a social movement for the reform of the American health care system.

III. Why a Social Movement for Health Care Reform Might Be Appropriate

A. Reason One

In general, reform is necessary to redress an injustice, in this case the injustice committed against the American people by not honoring their moral right to health care as supported by Part One of this dissertation. Thus, one reason that a social reform movement for health care reform might be appropriate is that the American health care system, prohibitively expensive and rationed by ability to pay, is, and for many years has been, seriously flawed and badly in need of reform. A core group of nearly fifty million Americans lack regular access to health care because they have no health insurance and cannot afford to pay for care on their own. In addition, approximately twice as many Americans go without health insurance, and therefore without regular access to health care, for at least part of every year. Many other Americans have inadequate health insurance and thus would face severe financial hardship or even bankruptcy if a family member should require extensive care. Moreover, lack of health insurance is no longer a problem confined to the poor and the unemployed, if in fact this was ever the case. Many middle class American families face the possibility of job loss and the consequent loss of health insurance because of continuing corporate downsizing. In addition, fewer corporations are providing health insurance benefits to new hires and those that do provide health benefits often provide coverage to the employee but not to dependents. Many Americans live with the insecurity that accompanies the fear of job loss and the subsequent loss of health insurance.⁵⁷³

⁵⁷³ Government employees and tenured faculty are, of course, exempt from these fears.

B. Reason Two

Beyond the fact that the American health care system needs to be reformed, a second reason to consider a social movement for health care reform is that there is some evidence that such a social movement could accomplish that reform. The greatest success in enacting legislation to provide health care, albeit to only a subset of the population, was Medicare in 1965.⁵⁷⁴ Senior citizens were both active and visible in the fight to win Medicare, engaging in petition drives, letter-writing campaigns, and organizing testimony for congressional debates on the issue of government financed health care for the elderly. Whereas in all previous attempts to enact any kind of health care legislation the coalition of antireform stakeholders,⁵⁷⁵ personified by the American Medical Association (AMA) set the terms of debate, with Medicare the senior citizens reserved that honor to themselves. Their campaign literature spelled out specifically what was in Medicare and why senior citizens needed Medicare, they distributed tens of millions of pieces of literature, and they targeted the AMA specifically for being against everything including much needed reform and for misrepresenting everything that

⁵⁷⁴ The Medicaid and SCHIP (State Children's Health Insurance Program) programs represent at least partial success in enacting legislation to provide health care to subsets of the population. Medicaid, Title XIX of the Social Security Act, was enacted at the same time as Medicare as a health care program for eligible individuals and families with low incomes and resources. SCHIP, Title XXI of the Social Security Act, was created in 1997 and expanded in 2009 to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. For an expanded discussion of Medicaid and SCHIP, see Chapter Four of this dissertation.

⁵⁷⁵ The coalition of antireform stakeholders can be defined as all those who have a vested interest in maintaining the status quo. For many years, in fact until the enactment of Medicare in 1965, the AMA was the most visible and vocal member of that coalition. Membership in the coalition varies with time but other stakeholders include, but are not limited to, hospitals, private insurers, corporations concerned with the escalating cost of health care benefits, and labor unions that preferred to have benefits gained through collective bargaining rather than being provided by the government. In recent years the Health Insurance Association of America (HIAA) and the Pharmaceutical Manufacturers Association (PMA) have become the dominant voice against national health insurance reform.

Medicare offered. The senior citizens convinced nearly three-quarters of Americans of the need for Medicare and this was enough public support to give the enactment of Medicare a very high priority on the administration's agenda. Seniors have also been very active in protecting benefits granted them under the Social Security Act and its various amendments.

C. Reason Three

Furthermore, a third reason to consider a social movement to accomplish health care reform is that other social movements have been successful in the past. These other social movements were necessary and were usually unpopular and at times were dangerous, yet persisted in the work required to correct other types of injustice. History records that nineteenth century American culture gave rise to two such social movements, one of which achieved its central purpose within the century and the other of which required two decades of work in the twentieth century in order to accomplish its purpose.

The abolition of slavery was not a new topic in the early nineteenth century. The issue of slavery was discussed repeatedly in the colonies and became a hotly debated topic in the Constitutional Convention. Nearly all of America's Founding Fathers were slave owners, and though all of them professed to abhor slavery, only a few emancipated his own slaves and none took any steps to abolish the institution. Some Quakers had begun to press the issue of abolition but their protests were parochial and not designed to enlist mass public support. One man not only saw the need to abolish slavery and extend equal rights to the freed slaves, but also took the lead in gathering the critical mass of public support needed to push the issue to the top of the national political agenda.

William Lloyd Garrison started his newspaper *The Liberator* to agitate the cause of

abolition and vowed from the very first issue that he would not back down and that he would be heard. He worked to found the New England Antislavery Society to agitate the cause of abolition at the local and regional level and to found the American Antislavery Society to agitate the cause at the national level. Garrison understood that the cause of justice demands action as well as, or even more than, words.

Likewise with woman's rights and suffrage. Many women had complained bitterly for many years about their inferior status and their lack of civil, legal, property, and political rights but it was Elizabeth Cady Stanton and a few like-minded women who took action to correct these injustices. Stanton organized the Seneca Falls Woman's Rights Convention, delivered her first public speech and call to action there, participated in drafting the Declaration of Sentiments of the nascent woman's rights movement, and insisted from the very beginning that women had to be granted the right to vote. Like Garrison, Stanton understood that justice requires action.

D. Reason Four

A fourth reason to consider a social movement for health care reform is that nothing else has been able to overcome the organized opposition of the coalition of antireform stakeholders dedicated to preserving the status quo. A social movement is a way to involve the American people directly in the process of change, to encourage the people to make their views known to the government in such a way that the government will take the necessary action to redress injustice and enact reform. When the government cannot or will not act to redress injustice, then it is incumbent upon the people to take the necessary action to accomplish reform. The American people, motivated and mobilized, can be an awesome force for change. A social reform

movement for health care reform could harness that force and accomplish the necessary changes. At this point, having considered why a social movement for health care reform might be appropriate, it is pertinent to ask how such a social reform movement might begin and develop.

IV. How a Social Reform Movement for Health Care Might Begin and Develop

A. Grassroots Level Activism

1. A Single Individual Begins the Work

A social movement to reform the American health care system will begin, as all social movements begin, at the grassroots level with a solitary individual who understands that the current system is unjust, because it is prohibitively expensive, is rationed by ability to pay, and does not provide universal access, and who does something about it. This individual will perceive what needs to be done, begin the work, and persist until it is accomplished. One of this individual's first actions most probably will be to enlist others, such as relatives, friends, and colleagues, into the cause. Other solitary individuals of like mind will join in the work and become the movement that will accomplish the great work of social change.

2. Work Begins in Several Places

It is possible, even probable, that the work of reform will begin in several places at about the same time. Most Americans are aware that the health care system is seriously flawed and in need of reform and many are willing to do something about it but only a few are prepared to begin and carry out the work of reform. Thus, when solitary individuals take action to redress the injustice of the contemporary American health care

system, they will find supporters for the cause. The initial actions might be as simple as talking to colleagues and neighbors, to begin building the nucleus of support for taking the necessary action to reform the system. Or the initial action could be more complex, getting the message of the need for change to more people than just neighbors and colleagues. William Lloyd Garrison founded his own newspaper, *The Liberator*, for the specific purpose of agitating the need to abolish slavery and grant full and equal rights to the emancipated slaves. Elizabeth Cady Stanton called a public meeting in Seneca Falls, New York to make it clear that women were being denied their rights, including the right to vote, and that it was time to act to secure those rights for all women. A contemporary activist might use the Internet, with a website and weblog, to gather support for the new reform movement.

3. Small Groups Form and Join Forces

Once the individual who initiates action begins to gather a nucleus of support for the cause of reform, s/he will begin to look for other individuals who might have also perceived the injustice and begun to take action to redress it. There may be groups of individuals committed to the cause of reform in the same or in nearby communities or in other states. Communicating and joining with other groups who are also committed to the cause of reform are reliable and practical ways of increasing the level of support for the cause and also of sharing the ideas that will ultimately clarify the issue to be agitated and the message that will present the issue to the public.

When the individual who moves beyond perceiving the need for reform to acting on that perception begins work, the issue to be agitated could be as inchoate as realizing that something needs to be done, as distinct as stating that the current health care system

must be transformed in a specific way,⁵⁷⁶ or somewhere in between. Even if it is not stated at the very beginning of the social movement, eventually the issue will have to be formulated and a message presenting the issue will have to be developed and presented to the public.

4. Structural Elements of a Social Reform Movement

A social reform movement is not unlike a political campaign or a marketing effort. However, whereas a political campaign sells a candidate and a salesman sells a product, a social reform movement sells an idea. A social movement for health care reform would require some of the same structural elements as a political campaign or a massive marketing effort, such as leadership, organization, accurate and readily available data and information, and the ability to react quickly to changing circumstances. How then might a contemporary social movement for health care reform develop leadership, define the issue to be agitated, formulate the message to be presented and communicate that message to the voting public? What symbols and what methods of communication would a contemporary Health Care Reform social movement utilize?

B. Leadership

The history of earlier social reform movements, notably Abolition and Woman's Right and Suffrage, indicate that visionary leadership is very important. It should be noted however, that visionary leadership is not mandatory for beginning the work but will be necessary to focus public opinion on the need for social reform in general and this

⁵⁷⁶ A social movement to reform the American health care system could, for example, call for radical change, such as transforming the current system into a universal access, single-payer system. Alternatively, a social movement to reform the American health care system could call for maintaining the current market-based approach to health care with the introduction of significant restrictions, regulations, and government oversight to guarantee access to affordable comprehensive health care for all Americans.

specific reform in particular. Although citizens and even leaders privately denounced slavery, and although many women were dissatisfied with their inferior social status, nothing was done to resolve either issue until visionary leaders, William Lloyd Garrison and Elizabeth Cady Stanton, emerged and took action. In contemporary society, the majority of the American people favor health care reform and work to accomplish reform is beginning at the grassroots level, but no visionary leader has as yet emerged to focus this public support into a force for political action.

1. Local Level

Leaders will emerge, and leadership is essential, at every level of the incipient social movement for health care reform. Activists are already working at the local level and local leaders are beginning to emerge, and these local leaders will be indispensable as the movement grows. Local leaders know the people at the grassroots level, live in the same communities, attend the same churches, and socialize with them. The people at the grassroots level are and will be the heart of the reform movement and local leaders understand the challenges and hardships that they face every day as well as the values they espouse. Thus, local leaders know how to talk to the people in terms they will understand and what to emphasize in order to attract people who are interested in but not yet fully committed to the cause of reform. Local leaders also know the business men and women in the community, the local clergy, and civic leaders, whose support will be crucial in moving forward with a social movement for health care reform.

2. State Level

Leadership at the state level is also critical to success. This second level of leadership will direct and coordinate the efforts of the various grassroots campaigns so

that each state will speak with one voice on the need for reform and provide a bloc of support for the movement. State leaders will devise strategy for the state level of activity and implement the national strategy. In addition, state leaders will need access to politicians, political advisors, economic advisers and a host of other leaders at the state level. State level leaders should also work with Congressional Representatives and Senators.

3. National Level

Leadership at the national level will be the most visible and these leaders will have the responsibility of mapping the strategy and tactics for the entire social movement for health care reform. Although it is not absolutely necessary, it would be beneficial if at least some of the national leaders were charismatic personalities.⁵⁷⁷ It will be absolutely imperative for national leaders to cultivate political insiders who can introduce health care reform bills and who know how to attach health care initiatives to less visible budget measures.⁵⁷⁸ Political insiders would include the influential congressional committee chairs and the civil servants who support them as well as supporters for the cause of health care reform. National leaders will also have to know how to tap into the expertise of Washington insiders, think tanks, policy institutes, universities, and others who support health care reform, understand the process by which issues that have public support get onto the national policy agenda, and know how to draft legislation and get it

⁵⁷⁷ Charismatic leaders draw attention, from the media as well as from the people at the grassroots level, and this can help to advance the cause. A charismatic leader can act as both spokesperson and lightning rod and thereby relieve others of the burden of delivering the right message at the right time and deflect the attacks and criticism of the opposition.

⁵⁷⁸ For more information on drafting and introducing legislation, see Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (New York, NY: Oxford University Press, 2005), Chapter Two.

enacted. These national leaders will also need economic advisers, publicity campaign expertise, and a staff with superb administrative skills.

C. Structure and Organization

The structure of the Health Care Reform organization will be closely allied to leadership and should emulate and reflect the organizational structure of the coalition of stakeholders that has defeated every past attempt to enact comprehensive health care legislation. The opposition has always had national leadership, state level organizations, and local networks capable of marshaling grassroots support. Past social movements, the few but notable instances when ordinary citizens defeated elite stakeholders, had strong organizations comparable to the federated structure of American government. This type of organizational structure clearly works so it will be necessary for a Health Care Reform movement to develop such a three-tiered coalition of local, state, and national support. The leadership discussed earlier incorporates the strength of the three-tiered organizational structure.⁵⁷⁹ The three-tiered organization can attract adherents at every level and past experience demonstrates that support will be needed at every level. Strong leadership in conjunction with organizational strength can develop and execute a campaign plan that will utilize the talents and energy of every person involved in and committed to Health Care Reform. A well-run organization tends to look successful and this aura tends to attract more adherents from all walks of life and thereby broaden the base of support for reform. The social movement for health care reform will have to attract as many committed supporters as possible because the Health Care Reform

⁵⁷⁹ The value of the three-tiered organizational structure was demonstrated very clearly in the last five years of the battle to achieve suffrage for women. Carrie Chapman Catt had both the administrative talent to create a multi-layer structure and the political acumen to exploit it.

movement will have to accomplish with numbers of adherents and the vote of each what the opposition has been able to defeat with political influence and nearly unlimited funding.

D. The Issue, the Message, and Identity

1. Issue and Message: An Introduction

Part of the function of reform movement leadership is to formulate the *issue* the movement is advocating and develop and refine the *message* that will present the issue to the uncommitted public. The issue and the message are inextricably intertwined, difficult to conceive, and harder still to accomplish. The relationship of issue and message is further complicated by the fact that definitions must be both broad and narrow. This concept is more easily understood in a concrete, practical sense than in an abstract, theoretical sense.

a. Pragmatic Achievability

The thesis of this dissertation is that a social reform movement to accomplish comprehensive reform of the American health care system is called for because justice demands reform and efforts to accomplish reform through the political and legal processes have failed. Thus, the focus of this dissertation is on pragmatic achievability, the practical aspects of how to accomplish comprehensive reform and not on the abstract philosophical foundation of the need for reform or a theoretical definition of what the reformed health care system should be. The practical aspects of accomplishing comprehensive reform entail selling the idea of comprehensive reform of the health care system to the American people and creating within them such a firm commitment to reform that the government will be compelled to act in response to the will of the people

rather than in response to the desires of special interest groups. The effort to persuade the American people that reform is necessary is neither abstract nor theoretical but is instead a practical application of marketing expertise.⁵⁸⁰

b. Broadly Defined Issue

It must be remembered that any social reform movement is working to gather support for a cause that is invariably complex, probably poorly understood, and possibly not widely accepted. Thus, what the reform movement is doing, in practical terms, is selling an idea, a complex, poorly understood, essentially unpopular idea, an idea that, when implemented, will entail a seismic shift in the tectonic plates of the social structure. Anyone who has ever sold anything that is complex, including a complex idea, understands intuitively that the issue, the message that presents the issue, and the relationship between issue and message must be defined broadly enough to capture and hold the attention of the audience — the buyers, the clients, the customers, the public — and narrowly enough to focus the efforts of the speaker — the marketing team, the social reform movement leaders. A broadly defined issue and message represent the end, the goal that is sought. It can be repeated frequently, will most probably not change much over the course of the social reform movement, and will eventually become somewhat of a watchword or slogan for what the movement is working to accomplish. An example of a broadly defined issue and message for a social movement for the reform of the American health care system might be: Access to comprehensive, affordable health care for all Americans.

⁵⁸⁰ The organized opposition to health care reform, especially the AMA at first and later both the HIAA and the PMA, understood this from the very beginning. They hired public relations firms that knew well the art of selling to conduct their campaigns against health care reform.

c. Narrowly Defined Issue

A narrowly defined issue, on the other hand, represents a means of achieving the broadly defined end. It will probably be held confidential within the movement for some period of time, and will almost certainly evolve over the course of the social reform movement. To understand why this is so, it should be remembered that a social reform movement will grow out of activism at the grassroots level and that work at the grassroots level will continue not only throughout the life of the social movement, but also through the successful enactment of reform legislation and beyond to the validation of that legislation as constitutional. It is probable that each group of grassroots activists will have their own ideas about what the narrowly defined issue should be. Some, for example, may advocate a single-payer system, others may favor some version of a strictly regulated private system, a third group may endorse some version of health savings accounts or tax incentives, and other groups may have other ideas about how to achieve success. All are aiming for the same goal, but have different paths to reaching that goal. However, as important as grassroots activism is, it is highly unlikely that hundreds or thousands of groups of grassroots activists, each group focusing on a slightly different way of achieving the goal of access to comprehensive, affordable health care for all Americans, will be successful if they act independently. Rather, small groups of grassroots activists will enter into alliances and form coalitions of activists, and thereby strengthen their voice and give them greater political influence than they would have if they were speaking individually.⁵⁸¹ In building alliances and forming coalitions of

⁵⁸¹ Consider the Clinton Health Care Reform effort of the 1990s: big business in general supported the Clinton plan but they had no organized voice to speak for them and so their message of support was too fragmented to have any positive effect. Small businesses, on the other hand, had little political influence

grassroots activists, a new focus may emerge, some means of achieving the end of health care reform that is not exactly what any of the parties advocated prior to joining in alliance, but is, nonetheless, still acceptable to all or nearly all the activist members of the newly-formed coalition. Thus, the leaders of the grassroots movements must know what it is they are negotiating, what they are gaining and what they may be giving up, in order to formulate the narrowly-defined focus of the coalition and then to sell that new focus to all the members of the coalition. This is one way that the narrowly defined issue and message will probably evolve over time. It is also possible that the narrowly defined focus of grassroots activists or coalitions of grassroots activists is simply not acceptable to the vast majority of the American people, the people whose support will be required in order to persuade the government, executive and legislative branches, to take action. If, for example, the narrowly defined focus of a social movement for the reform of the American health care system is that reform can only be achieved through a single-payer system, and the American people are not prepared to accept a single-payer system, then the effort to achieve health care reform will most probably fail once again.

d. Need Both Broad and Narrow Definitions of the Issue

Thus, the broad definition of the issue will change little, if at all, as the social reform movement begins and moves forward. The narrow definition of the issue will almost certainly have to change and evolve over time in order to define a means of

but they did have the National Federation of Independent Business (NFIB) to deliver a unified, coherent message in opposition to the Clinton plan. Small businesses thus had a disproportionate effect on the reform effort because they were able to deliver a unified message.

reaching the goal that is acceptable to all or nearly all Americans, that is politically feasible, and thus meets the criteria of pragmatic achievability.⁵⁸²

The issue and message must be broad, open to interpretation and able to attract a wide variety of adherents. Nearly everyone will find something to agree and identify with and thus to accept.⁵⁸³ The details of implementation, how to achieve the goal of access to comprehensive, affordable health care for all Americans, should not cloud the big picture of the issue, at least not in the early days of the social reform movement.⁵⁸⁴ It must be remembered that the issue of health care reform will never move beyond grassroots support to political enactment without the support of the policy brokers and decision makers. Therefore it would be in the best interest of success to be open in defining what the Health Care Reform movement aims to accomplish, that is, what issue the social movement is agitating, but cryptic and enigmatic on the means to accomplishing that reform.

2. The Issue

The *issue* is the goal of the social reform movement, what the movement is working to accomplish. It is the cause being advocated and agitated. For the abolitionists, the issue was abolishing both the institution and the constitutional

⁵⁸² It is important to understand that the work to reform health care is not a voyage of discovery: it is not practical to start the journey without having some idea of where you are going and how you are going to get there. This is another reason that defining the issue narrowly and precisely is as important as defining the issue broadly and ambiguously.

⁵⁸³ Prospective adherents may not agree on how to reform the health care system but can agree that it needs to be reformed. An ambiguous definition of the issue will attract these prospective adherents.

⁵⁸⁴ In my former career, I would call this “selling to the generals.” They needed to know at a very high level what we were planning to do, but not how we were planning to accomplish the change. The details of implementation were reserved to the NCOs who would actually do the work.

protection of slavery. For the suffragists, the issue was gaining for women civic, legal, political, and property rights, including the right to vote. For an American Health Care Reform movement, the issue will most likely be to reform the American health care system to provide access to comprehensive, affordable health care for all Americans.

The issue, as discussed previously, will have to be defined both broadly and narrowly. The broad, ambiguous definition of the issue will help to attract both a wide variety of potential adherents to the cause and also the ultimate decision makers. The narrow, precise definition of the issue is important both as a measurement of success and as a guide for those who will be creating the repertoire, running the campaign, and orchestrating the public displays of worthiness, unity, numbers, and commitment.

3. The Message

The *message* is more than the issue. The message is how the issue is presented to current and future supporters and includes, for example, persuasive points on why this issue is important, in general and specifically to each individual, and how this campaign differs from previous attempts to enact health care reform legislation. The message must also counter opposition propaganda.⁵⁸⁵

⁵⁸⁵ For example, the organized coalition of antireform stakeholders consistently raises the specter of socialized medicine in response to any suggestion for national health insurance. Few Americans know what socialized medicine is but nearly all recognize the term as a link to communism and every American knows that even in the twenty-first century it is important to be anticommunist. Therefore if this proposed change is communist it is something to be avoided. Similarly, during the fight for woman suffrage, the opposition consistently raised emotional arguments that women could exert more influence at home than pressure at the ballot box and that women's higher mission was in the home where the men would take care of them. The anti-suffrage cohorts conjured up hideous visions of Amazonian women pitted against men. No rational appeals to fact could overcome the fear engendered by both the emotional arguments of the anti-suffrage cohorts and the specter of socialized medicine raised by the opponents of health care reform. Rational arguments address the intellect while fear resides in the emotions.

The message will have to be carefully crafted so that the Health Care Reform movement controls the debate. Further, the message will have to be refined so that it speaks to each audience in terms that the particular audience can relate to and understand. The message also must be fundamentally true. Americans are capable of reforming their health care system and they can do it if only they will. The message can aid in shaping and strengthening that national will so that this time proposed reform will become enacted reality.

4. Identity

Identity refers to those on whose behalf the movement is conducting its campaigns of collective action. Thus, the abolitionist movement worked on behalf of the slaves who could not agitate on their own behalf. The woman's rights and suffrage movement was waged on behalf of all women, some of whom did not actively participate in the campaigns of collective action but who benefited nevertheless.

The question of identity was not an issue in previous social movements. The abolitionists identified slaves by the color of their skin because all slaves were black, although not all blacks were slaves. The beneficiaries of the woman's rights and suffrage movement were recognized by their gender. More recently, in the movement that accompanied the enactment of Medicare, the senior citizens were identified by their age.

A social movement for reform of the American health care system will wage its collective action campaigns on behalf of all Americans because all Americans have a moral right to health care, a right that is not met by the current system. Some Americans suffer more than others under the current system, for example, the uninsured and the underinsured, and even the insured face escalating costs and eroding benefits. Neither

the uninsured nor the underinsured nor the insured facing rising costs and shrinking benefits share any easily identifiable visible characteristic and thus the identity of those on whose behalf the movement is agitating is all Americans. However, appropriate symbols would help to personify the issue and more precisely identify at least some of those on whose behalf the movement is agitating for reform.

E. Symbols

Symbols can be powerful reminders of a cause. Consider, for example, the peace symbol. It is highly recognizable and immediately identified with the cause of peace, yet it does not have any apparent connection to the cause. The yellow ribbon indicates support for the troops, the red ribbon indicates support for AIDS patients, and the pink ribbon indicates support for breast cancer research. Yet none of these has any overt connection to the cause it symbolizes. They are all highly abstract and ambiguous. The symbols are meaningful because people invest them with meaning.

For many years the March of Dimes would select a poster child to be the visible image of the campaign against polio. The poster child would thus personify and make concrete the abstraction of the fight to eradicate polio.

The question, then, is what symbol or symbols would be appropriate for the Health Care Reform movement? How can the number of uninsured be transformed from a statistic into a concrete living reality? How can symbols depict the fear of insecurity that the uninsured live with? How can those symbols be enlarged to depict the possibility that nearly all face the threat of the insecurity that accompanies the possible loss of job and subsequent loss of health coverage? These are some of the questions to be considered in regard to creating or adapting symbols for a Health Care Reform

movement. However, it may be possible to draw on the human experience to find stories that characterize the problem and act as a springboard toward developing a symbol that uniquely characterizes the Health Care Reform movement.⁵⁸⁶

It is highly likely that a symbol or symbols will develop spontaneously at, for example, the local grassroots level of agitation and one or more may evolve into or be adapted to become a national symbol of the Health Care Reform movement. However, as a starting point, the idea of a “poster child” should be considered. The poster child immediately puts a face on the issue and most people relate more easily to persons than to ideas or facts.⁵⁸⁷

F. Communications

Effective communications methods will be essential for the Health Care Reform social movement in order to spread the positive message of reform to supporters and potential supporters, to counter the negative messages of the opposition, to attract media attention, and for other purposes as well. Movement leaders will need to be able to communicate with each other, top-down, bottom-up, and peer-to-peer.

1. Communications Methods

The Internet, electronic mail, and text messaging are very popular methods of communication, especially among the young and upwardly mobile and should definitely

⁵⁸⁶ The Biblical story of David and Goliath might be adapted as a symbol of the powerlessness of the ordinary people against the might and strength of the organized opposition. The folklore story of Jack the Giant Killer could be adapted for the same reason. The mythological Gordian Knot could symbolize both the complexity of the problem and the boldness that will be required to resolve it. An iceberg could symbolize both the size of the problem and the hidden power of the opposition.

⁵⁸⁷ Most people immediately identify the Civil Rights movement when they see pictures of Rosa Parks or Martin Luther King, Jr. In regard to health care reform, Michael Moore started personifying the problems of the American health care system in his movie *Sicko*.

be employed but should not be the only or even the primary methods of communication. Many of the citizens whose support will be critical to the success of the movement may not have access to the Internet, electronic mail, or text messaging. Printed communications may be the best way to address a large number of people of varying education, social status, and access to technology. However, a dual approach of sending printed matter and simultaneously posting the information to movement websites could be very effective.

A newspaper or circular should be considered as a vehicle for agitating the Health Care Reform message in the movement's terms, not colored by the bias of any other reporting medium. It would be one place where the reform message would be neither diluted nor misrepresented. Past social movements have published newspapers for just that reason. William Lloyd Garrison founded *The Liberator* specifically to agitate the message of the abolitionist movement and focused on that message until the Thirteenth Amendment was ratified. The Woman's Rights and Suffrage movement relied on the abolitionist newspapers until they finally got a newspaper of their own, *The Revolution*, in 1868. Although other forms of communication may be more convenient, the printed word will be more thoughtful, conceivably more accurate, and certainly more durable.⁵⁸⁸

2. Equal Access to Accurate Information

However many and whatever forms of communications are employed, the intent should be to give all supporters equal access to the information. Ultimately it is the

⁵⁸⁸ Some local health care reform movements rely on electronic transmission of newsletters, weblogs for feedback, and email and text messaging for communicating with members and these are convenient most of the time. However, comments in weblogs make you understand how little thought is put into anything that is not a formal document. And with nothing but electronic media, it is difficult to leave an interesting article with a wavering supporter "accidentally."

grassroots support that will make the movement successful and it is to their level that communications should be tailored. Accurate and timely information presented in an interesting manner using all important communications techniques will help to build sufficient public support to convince decision makers that the issue ought to be part of the national policy agenda. To ensure that the information is accurate and timely and to control the flow of information, a communications director will be as important to a Health Care Reform movement as such an individual is to political campaigns and the White House.

Evidence suggests that a certain amount of work has been and is being done at the local level and that some links have been established with state and national level groups. However, at the moment at least, such national organizations as exist either are acting as clearing houses for the exchange of information among local and state level health care reform groups or are organizations dedicated to reform in general without any specific affinity with health care reform. No individual or group has emerged as a real leader focused specifically on health care reform.

3. Seminal Event as Catalyst

Despite the recent successful enactment of the health insurance reform legislation in March 2010, it might still be necessary for some seminal event⁵⁸⁹ to act as a catalyst for a social movement to continue the work of health care reform and to become a focal point for all the existing organizations. In December 1955 such a seminal event occurred

⁵⁸⁹ The recent enactment of the health insurance reform legislation is a significant first step in accomplishing reform but there is still much work to be done. A seminal event might be necessary to focus the attention of Americans, activists and public, on the continuing effort to accomplish substantive reform of the American health care system.

in Montgomery, Alabama⁵⁹⁰ and this served as both catalyst and focal point for the Civil Rights movement. Similarly, Cesar Chavez, a migrant farm worker who became a labor leader, called national attention to the plight of the migrant workers by organizing a four-year boycott of table grapes, the most successful boycott in American history.⁵⁹¹

It is possible but not at all certain that some comparable seminal event⁵⁹² will have to occur in order to unite health care activists into a cohesive, coherent reform movement and at the same time begin attracting public attention to the cause and raising public awareness of the need continuing the fight to accomplish substantive reform of the American health care system. If such a seminal event does occur,⁵⁹³ a significant portion

⁵⁹⁰ A young black woman named Rosa Parks refused to give up her seat on a bus. This was a simple act in itself but one that required great courage in that place at that time. This simple act led to a year-long bus boycott by the black community, catapulted a young black minister named Martin Luther King, Jr. into national prominence, and was the seminal event that united black citizens in the Civil Rights movement that eventually ended segregation in the South.

⁵⁹¹ The boycott was both a form of political action and also a seminal event that got the attention of the American public and united the migrant workers behind the leadership of Chavez who organized them into the United Farm Workers. The migrant workers suffered because of the harsh and dangerous working conditions, the backbreaking work of picking, the low wages, the lack of security, and the deplorable living conditions they were forced to endure.

⁵⁹² This seminal event could be something that is not directly related to health care but still focuses attention on social and economic inequities. The Great Depression, for example, focused attention on the plight of the unemployed and the elderly and thus precipitated unemployment benefits and Social Security. Both unemployment and impoverished elderly existed prior to the Great Depression but their plight was greatly exacerbated by it. The current (late 2008) financial crisis delineates that health care cost burden borne by American business, a burden that affects the ability of American products to compete in the global market. Thus, this current financial crisis could precipitate health care reform in order to make American products more competitive in the global economy.

⁵⁹³ If the stock market crash of 1929 with the subsequent global Great Depression is considered to be the seminal event that precipitated the government intervention into the private sector that brought about social welfare programs such as old-age pensions and unemployment compensation through the Social Security Act, then it is possible that the current and ongoing (late 2008 into 2009) economic crisis constitutes the seminal event that could bring about additional social welfare programs including universal health care for Americans. Government-funded health care could relieve the burden currently borne by employers and bring costs more in line with those borne by foreign competitors and thus help to revitalize American industry.

of the support structure should already be in place to keep the Health Care Reform movement alive and active.

V. Interim Work: Prelude to the Health Care Reform Social Movement

Recent polls indicate that more than at any time in history, the American people are in favor of health care reform but much work remains to be done to transform the general feeling of favoring reform into a true commitment to work for reform until it is accomplished. Work is being done at the state level to transform popular support into political action and workable legislation. At least twenty-eight states have some type of organized effort working to put health care reform on the political agenda and at least two organizations at the national level network the state and local organizations and serve as conduits for the exchange of information.

More than a third of the states are taking some kind of action toward health care reform. Organizations dedicated to building public support for health care reform are active in more than half the states. Thus, the states have truly become the crucible for refining ideas about building commitment to a reform of the American health care system. The variety of programs proposed and the range of financing methods considered are measures of both American ingenuity and ability to compromise. The number of groups that have come together in coalitions to support proposed legislation is an indication of a willingness to subordinate individualism and private interests to the good of the community, at least some of the time.

The reform that has been accomplished so far has been the result of a combination of political leadership and grassroots advocacy. State political leadership at the highest level can create the political will to achieve meaningful reform. Presumably national

political leadership at the highest level could also foster the political will to achieve meaningful reform at the national level. Strong, active, organized grassroots advocacy is and will be needed over an extended period of time, both before and after reform is implemented and a high degree of vigilance is and will be needed during the period when the legislation is being debated in the legislature and the Congress.

Current experience in the states indicates that comprehensive health reform proposals that phase in over a period of several years are easier to pass but may be difficult to maintain intact over the period of implementation. It is also easier to build support for expanded access than to control cost but costs must be addressed and controlled or the reform will not be sustainable.

In health care reform, as in any major undertaking, there is a moment to act and a moment to wait. Therefore it is important to be aware of the political climate in order to recognize when the moment to act presents itself.

The organized coalition of antireform stakeholders will oppose most proposed health care reform legislation but they must be persuaded to put the larger public interests ahead of their own. Experience has shown that this is possible, although it is not by any means easy. The moral issue of justice for all or the more prosaic approach of enlightened self-interest may help to break through the entrenched opposition.

Accomplishing comprehensive socioeconomic change has never been easy, yet social movements have altered the course of American history in the past and conceivably can do so again in the present or the future. Therefore it is appropriate to ask what lessons can be learned from past successful social reform movements, specifically Abolition and Woman's Rights and Suffrage.

VI. Lessons That Might Be Learned from Previous Social Reform Movements

Earlier chapters of this dissertation examined both Abolition and Woman's Rights and Suffrage as paradigms of social movements that accomplished great socioeconomic change and altered the course of American history. What lessons might a contemporary social movement for health care reform learn from these past actions?

A. Abolition

1. Begin the Work

The work to abolish slavery began before the Abolition Movement was launched, but the work was piecemeal, with neither a coherent message nor a cohesive plan for accomplishing the work. Although nearly all of the Northern states either had taken or were taking action to abolish slavery at the state level, little had been done to address slavery as a national issue until 1831 when William Lloyd Garrison began publishing *The Liberator*, the newspaper he founded for the express purpose of agitating the cause of abolition. For Garrison, the issue was very clear: all slaves had to be emancipated immediately and granted their full and equal rights as enumerated in the Declaration of Independence. He communicated the antislavery message every week in *The Liberator* for thirty-five years, a message that radical abolitionists understood to be immediate emancipation with full and equal rights but moderate abolitionists and potential supporters interpreted as opposition to the spread of slavery to the frontier territories. Nevertheless, the message was palatable enough to gain popular support for the cause of abolition. Garrison also founded local, state and national organizations to agitate the cause of abolition and coordinate the work of the abolitionists.

2. Formulate the Issue and Repeat the Message

Thus, the Abolition Movement teaches the importance of a visionary leader who moves beyond thinking and talking to begin the work, to formulate the issue to be agitated, to hone that issue into a message that can be understood and accepted by a wide variety of people, and to repeat that message until a critical mass of support builds and political leaders are forced to take action because it is the will of the people. Garrison and the abolitionists persevered for thirty-five years, against entrenched Slave Power and seemingly unbeatable odds, fighting to dismantle an institution that had existed for millennia and had Constitutional protection in the United States. Thus the Abolition Movement also teaches the necessity of perseverance against formidable opposition.

3. Use Multiple Practices to Get the Attention of the Uncommitted Public

The abolitionists developed a variety of practices to get the message out to the public and to demonstrate the growing interest in abolition to the authorities. They gathered signatures on petitions supporting abolition and submitted these petitions to Congress even though Congress had imposed a ‘gag rule’ and refused to accept the petitions. They were not afraid to break into new territory, such as when the Grimké sisters began speaking in public to mixed audiences of men and women and called down the wrath of the churches. Rather than retreat into silence, the abolitionists began to support equal rights for women as well as immediate emancipation with equal rights for slaves. Thus the Abolition Movement teaches the importance of being both creative and open to new experiences and of recognizing injustice beyond the limits of the issue being agitated.

The proliferation of antislavery organizations indicates the importance of the work at the grassroots level, with local organizations that activists, supporters, and potential supporters can relate to and identify with. The overall structure of antislavery organizations at local, state, and national levels indicates both the importance of coordinating the work and optimizing the use of scarce resources and the necessity of compromise when methods of achieving reform differ.⁵⁹⁴

B. Woman's Rights and Suffrage

1. Make the Public Aware that the Work Has Begun

Like abolition, work to obtain some rights for women, such as the right to be educated and the right to speak in public, began prior to the launching of the Woman's Rights and Suffrage movement. However, the organized effort to secure equal rights for women began when Elizabeth Cady Stanton, a visionary leader who understood that without the right to vote women would never gain equality, and four other women⁵⁹⁵ called a public meeting in Seneca Falls, New York in July 1848. One of the almost immediate results of the Seneca Falls meeting was that other women in other places who also chafed under the existing patriarchal social system realized that they were not alone, that there were others who felt as they did and were willing to do something about the inequality. This is an important lesson for a Health Care Reform social movement.

People who are fighting the current health care system, who are desperate because they

⁵⁹⁴ See Chapter Six, specifically the discussion of the *Amistad* case. See also David Brion Davis, *Inhuman Bondage: The Rise and Fall of Slavery in the New World* (New York, NY: Oxford University Press, 2006), Chapter 1. and Henry Mayer, *All on Fire: William Lloyd Garrison and the Abolition of Slavery* (New York, NY: St. Martin's Press, 1998), Chapter 15.

⁵⁹⁵ The four other women were Lucretia Mott, Martha Wright (Lucretia Mott's sister), Jane Hunt, and Mary Ann McClintock.

do not have any or enough health care insurance, need to know that others are facing the same problems and that working together they should be able to bring about necessary reform.

Unlike abolition, Woman's Rights and Suffrage fought many battles on many fronts simultaneously. The slaves needed liberty before any other rights but women could fight for and gain many rights independent of the right to vote. The necessity of being aware of what reforms can be gained prior to major reform such as a national health insurance system is another important lesson to be learned from the Woman's Rights and Suffrage movement.

2. Need Both Visionary Leader and Superb Administrator

Although the Woman's Rights and Suffrage movement was begun by a visionary leader, the actual work of bringing the suffrage question to the national agenda and accomplishing the necessary tasks to get the federal suffrage amendment passed by Congress and ratified by the states was done under the guidance of a leader who was a superb administrator. This is yet another lesson to be learned from Woman's Rights and Suffrage, that it will be necessary to have superb administrators working for Health Care Reform, people who can keep both the big picture and the detailed tasks needed to complete the big picture in focus simultaneously.

Furthermore, it is important to be realistic and address the work to be done in practical terms. Carrie Chapman Catt recognized that the issue of woman suffrage was a political issue that could only be resolved by political action. She understood that gaining woman suffrage was tantamount to war between the suffragists and the anti-suffrage special interest groups. Therefore, Catt developed a battle plan for winning

suffrage as a general would for winning a war, using military thinking and the terminology of strategy, tactics, and operational tasks, and creating confusion in the minds of the opposition regarding where the real battle was being waged. Catt, the NAWSA board, and the state-level organizations worked together to execute her battle plan and succeeded in gaining the vote for American women.

3. Social Reform is Ultimately a Political Issue

Perhaps the most important lesson to be learned from Abolition and Woman's Rights and Suffrage is that the work of the social movement will ultimately become and must be addressed as a political issue. Carrie Chapman Catt recognized this and developed and executed the battle plan that finally gained for American women the right to vote. Even William Lloyd Garrison, who agitated abolition as a moral issue for more than thirty years, campaigned for Lincoln's reelection because he understood that emancipation and equal rights could only come about through the political process.

Both Abolition and Woman's Rights and Suffrage had strong visionary leaders, leaders who not only recognized what needed to be done but also took the action to start the work. Garrison understood that freedom not only had to be immediate, but also that it necessarily implied equal rights of citizenship for the freed men and women. He was able to envision a just society that did not tolerate slavery and that granted full rights of citizenship to all and he made this vision the heart of his message of immediatism.

Elizabeth Cady Stanton understood that without the right to vote, women were and would be powerless to achieve the basic liberties promised in the Declaration of Independence. Thus, the right to full participation in the political process was part of her vision of a just society and she insisted on suffrage in addition to other rights for women from the very

beginning of the woman's rights movement. Major socioeconomic change was effected in America because Garrison, Stanton, and other like-minded individuals were able to envision a better, more just world and did the necessary work to make their visions a reality. Others, however, for example those opposed to comprehensive health care reform, envision the status quo as the best of all possible worlds and work diligently to prevent any changes.

VII. Lessons That Might Be Learned from the Success of the Opponents of Health Care Reform

The opponents of Health Care Reform are an organized coalition of stakeholders with a vested interest in maintaining the status quo. This coalition includes, but is not limited to, health care insurers, health care providers, physicians, surgeons, nurses, hospitals, the pharmaceutical industry and others that profit from the health care system as it is currently structured. For many years the American Medical Association (AMA) spearheaded the opposition to reform and acted as spokesman. More recently the Health Insurance Association of America (HIAA) replaced the AMA as leader and spokesman for the opposition. The Pharmaceutical Manufacturers Association (PMA) has also vociferously opposed health care reform.⁵⁹⁶

The AMA defined the issue early in the twentieth century and it has remained essentially unchanged in the intervening years. In addition to defining the issue, the AMA kept it very close to the vest, strictly internal to the medical profession. In somewhat simplistic terms, the issue is to preserve the autonomy of the medical profession and retain the lucrative fee-for-service practice.

⁵⁹⁶ I tend to use the AMA as a shorthand notation for the organized coalition of antireform stakeholders.

A. The Fear Factor

The message was entirely different than the issue and was designed to arouse fear, the fear of “socialized medicine.” The AMA introduced the specter of socialism, socialized medicine, and creeping communism around the time of World War I. The idea of compulsory national health insurance was tainted as un-American because it had originated in Germany and Germany was the enemy in World War I. After the Russian Revolution, anti-communist sentiment began and grew and the leaders of the AMA “branded national health insurance as a detestable form of ‘socialism’.”⁵⁹⁷ The opponents of Health Care Reform played the “socialized medicine” card successfully for many years in spite of the fact that few Americans understood what “socialized medicine” is. The association of socialism with communism was enough to prevent many Americans from supporting any proposed health care reform measures.

More recently the message has changed somewhat, but is still oriented toward arousing fear. In the 1990s, the HIAA acted as spokesman for the organized coalition of stakeholders opposed to comprehensive health care reform and the message to Americans, conveyed through ads on television, did not denounce reform outright but made vague statements about health care reform the general message of which was loss of control. A second and more aggressive set of television ads featured a husband and wife, Harry and Louise, sitting at the kitchen table worrying about how the Clinton plan would affect their coverage. “The Harry and Louise ads generated numerous media commentaries, counterresponses, spoofs, and cartoons.”⁵⁹⁸ Although more than half of

⁵⁹⁷ Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge, MA: Harvard University Press, 1970), p. 32.

⁵⁹⁸ Quadagno, *One Nation, Uninsured*, p. 190.

those who saw the ads felt they were misleading, completely untrue, or more wrong than right, Harry and Louise helped to frame health care reform in a way that shook public confidence.

B. Extensive Use of Multiple Methods of Communication

In every anti-reform campaign, the opposition has used every possible form of communication, from the oldest to the newest and everything in between. Furthermore, the opponents of reform have always treated their efforts as exactly what they are, massive marketing campaigns. They hired public relations firms who then sold the message to the American public and used time-tested marketing techniques to sell their product.⁵⁹⁹ The public relations firms working for the opponents of health care reform never addressed the details of any reform measures being proposed. Rather, they convinced the public that health care reform was un-American, that health care reform was socialism or even creeping communism, and that health care reform would mean the end of American life as Americans knew it. After the public relations campaigns, Americans withdrew their support for health care reform.

What should be learned from the success of the organized opposition to health care reform is the importance of repeating the message and the necessity of treating a campaign for Health Care Reform as a massive marketing effort rather than as a crusade for justice. Justice may provide the underlying reason, but the need for reform must be addressed in the marketplace, using the language that buyers — voters — understand and

⁵⁹⁹ One technique that was used is known as the “FUD” factor in marketing: Fear, Uncertainty, Doubt. Products – or in this case ideas – can be sold without ever disparaging the competitor’s product simply by engendering an atmosphere of fear, enough fear to make the buyer uncertain and therefore doubt the value of the competitor’s product. The competitor’s product, of course, is whatever health care reform measure is being proposed.

accept. Further, once the public — the American people — have become committed to the need for health care reform, the focus must necessarily shift to the political arena. Agitation that begins in the streets at the grassroots level must ultimately be resolved in the halls of government.

VIII. Status of Health Care Reform in America

A. Work in Progress

The work to accomplish health care reform has begun at the local level and has fostered interest at the state and national levels, but as yet no visionary leader has emerged to solidify the work being done into a coherent, cohesive message and to broadcast that message to the larger community of the American people. The abolitionist movement agitated the issue of the injustice of slavery and the woman's rights and suffrage movement agitated the issue of the injustice of denying women their civil, legal, property, and political rights. The injustice to be redressed by the reform of the health care system has not yet been formulated and honed into a clear and concise issue to be agitated.⁶⁰⁰ While it is important to define the issue ambiguously enough to attract a broad base of adherents to the cause of health care reform, not defining the issue at all makes it difficult if not impossible to agitate for change. Further, leaving the issue undefined suggests that the advocates of reform either do not know or do not understand what they are advocating. An undefined issue means that there is no specific message to

⁶⁰⁰ The complex health care issue includes the millions of Americans who have no regular access to health care because they have no health insurance, the additional millions of Americans who have insufficient health insurance to cover a catastrophic illness, the millions more who face rising costs and diminishing coverage, and the high cost and relatively poor outcomes of the current American health care system. At one time the issue was to provide universal access through some form of government-financed national health insurance program, but that has been defeated so many times that reformers seem reluctant to make it the focal point of a new campaign.

be presented to supporters and potential supporters but, even if the issue were to be defined and the message formulated, there is as yet no specific vehicle for disseminating that message. However, in spite of the apparent lack of coordination among existing health care reform organizations, some limited success is being achieved as the states move to take the action that has so far been forestalled at the federal level. This is comparable to the interim success achieved by the abolitionists and the suffragists. Various Northern states abolished slavery at the state level before the Emancipation Proclamation was issued and the Thirteenth Amendment enacted and ratified. Women gained full or partial suffrage in some of the territories and states before the Nineteenth Amendment guaranteed suffrage at the federal level.

As the work for health care reform moves forward, as the leadership emerges, the issue is defined, the message formulated, and the communications vehicle designated, and as the movement begins to transform the American attitude from generally favoring reform to being totally committed to reform, the emphasis must be on communal activism and practical initiatives. Discussion and theory, no matter how erudite the discussion or elegant the theory, are not enough to solve the problem of how to effect comprehensive reform. Both must give way to action. Health Care Reform activists must address the problem where it exists, in the marketplace of the American social and political system, with the people affected by lack of access, dwindling care and escalating costs, in language they can understand, the language of the marketplace and ordinary everyday American life. The American people must be firmly convinced that reform, specifically reform as advocated by the Health Care Reform movement, is necessary and their

commitment to reform must be firm and unwavering⁶⁰¹ because they are the public whose opinion is essential to the success of the movement. Heretofore, in every previous attempt at health care reform, there was little public demand, no grassroots force, and no massive public clamor and so legislators did not perceive any need to go forward.⁶⁰²

At the theoretical level, there is near unanimity that the current health care system is unjust and must be changed. At the practical level, a social reform movement should provide the impetus to accomplish the necessary reform. What remains to be done to achieve, for example, universal access?

B. Work to be Done

When action at the grassroots level of American society grows beyond its present embryonic state into a recognizable Health Care Reform social movement, what, specifically, should the movement work to accomplish? The obvious answer is reform of the health care system, but what form might or should the reformed system take? It is important to keep pragmatic achievability in mind and to agitate for some form of health care system that has a high probability of being enacted and implemented.

Recent polls indicate that at the present time more Americans favor health care reform than at any time in the past. However, there is a vast gulf between favoring reform and being totally committed to reform and this is the gulf that a social movement

⁶⁰¹ The Senior Citizens movement has been very effective at building and maintaining unwavering public support for the cause at hand. The fight for Medicare, for example, presents a paradigm that could be effective in a contemporary Health Care Reform movement. Senior citizens were prepared to counter every attack on the proposed system and never wavered in their support of it. Their work contributed to a strong public opinion in favor of the legislation. Senior citizens also mobilized to protest the enactment of Medicare Catastrophic Coverage and created such a wave of negative public opinion that Congress repealed the legislation sixteen months after enacting it.

⁶⁰² For more detail on the critical importance of public opinion, see Quadagno, *One Nation, Uninsured*, Chapters 2 and 5-6.

must cross. As in any major undertaking, there is a moment to act and a moment to wait and the current level of public support is an indication that this may be the moment to act. A social movement for Health Care Reform must work with the American people to move a critical mass of Americans from merely favoring reform to being totally committed to reform, a commitment so strong that no fear-arousing or misleading argument against reform will sway that commitment. The numbers of Americans committed to reform and the strength of that commitment should provide the Health Care Reform movement with necessary leverage to compel the government to act in accordance with the will of the people and not according to the wishes of the special interest groups. With the commitment of the people and the concurrence of the government, reform can be accomplished.

1. Possible Scenario for Health Care Reform

There are three basic models for the provision of health care in all developed democracies, the private insurance model, the social insurance model, and the national insurance model. The United States is the only developed democracy that ties health care to private insurance and it is the only developed democracy to have gross inequities in the delivery of health care to its residents. Market forces alone will not accomplish equity and universal access. Reform will require active participation of the federal government.

a. Single Payer System

A Health Care Reform social movement could work to accomplish a system of national health insurance that provides universal access through a single payer financed by universal taxation, private premiums, or both, if such a system were acceptable to the majority of the American people. There are several reasons that the American health care

system could benefit from this form of health care system. First, it is the most just and most equitable system and if a Health Care Reform movement does not demand justice, who will? Second, it is more efficient and cost-effective than other systems. Third, there is precedent for establishing a system of national health insurance that provides universal access through a single payer financed by universal taxation, private premiums, or both.⁶⁰³ Fourth, the existence of this precedent indicates that experience, expertise, and the infrastructure necessary for implementing such a system are already in place. Moreover, past mistakes can be corrected or avoided, and much can be learned from other nations that have already implemented comparable systems.⁶⁰⁴ The question that must be asked is whether this form of health care system meets the criterion of pragmatic achievability.⁶⁰⁵

b. Improved Access and Equity of Care

A national health insurance program would improve access to the health care system and equity of care because all would be guaranteed a standard package of basic health care benefits.⁶⁰⁶ It would also relieve stress and anxiety for a significant segment

⁶⁰³ The precedent is, of course, Medicare, a system that provides national health insurance with universal access through a single payer financed by universal taxation, private premiums, or both to a segment of the population. The experience gained and the expertise acquired during the start-up phase of Medicare are well-documented and the structure is in place but would, of course, have to be expanded.

⁶⁰⁴ The reformed system should also incur fewer start-up costs than might be associated with a switch to a single-payer system, since most of these costs were already absorbed in the implementation of Medicare.

⁶⁰⁵ If a single payer universal access health care system does not meet the criterion of pragmatic achievability, then some other form of universal access system will have to be advocated. It is even possible that universal access to affordable comprehensive health care could be achieved under some variation of the current market-based system provided that sufficient specific restrictions, regulations, and government oversight are in place and effective.

⁶⁰⁶ A two-tiered system could be acceptable as long as the basic minimum package includes all the services that a currently well-insured member of the middle class would consider an acceptable package for self and family.

of the population because knowing that health care would be available when needed at some future time would contribute to enhanced peace of mind in the present. National health insurance would also provide the largest community available, that of the entire population of the United States, for spreading the risks in a community rating system. An added moral benefit is that national health insurance would help to “create an enhanced sense of community and underscore the social character of health and sickness.”⁶⁰⁷

Risk-sharing across the population also means, or should mean, cost-sharing across the population through a system of taxation.⁶⁰⁸ It is essential that everyone contribute something to the cost of health care to keep the focus on justice and avoid any insinuation of a dole or social stigma of a handout to the less well off and so to preserve the inherent human dignity of all. “No society guarantees health care access to everyone unless all contribute according to ability to pay.”⁶⁰⁹

A system of national health insurance with universal access and both risk-sharing and cost-sharing spread across the entire population implies a mandatory system as the only way to guarantee that the entire population participates in the pool. Moreover, a mandatory system “can be justified by its inherent rationality...[as] an investment in maintaining an enhanced range of rational choices in the future.”⁶¹⁰ A mandatory

⁶⁰⁷ Charles J. Dougherty, *American Health Care: Realities, Rights, and Reforms* (New York, NY: Oxford University Press, 1988), p. 168.

⁶⁰⁸ Progressive taxation might be required. This or any alternative financing scheme would be something that economists, fully committed to the cause of national health insurance, economists with access to policy makers and capable of communicating with the American people in language they can understand, should work out in detail.

⁶⁰⁹ Dougherty, *American Health Care*, p. 169.

⁶¹⁰ Dougherty, *American Health Care*, p. 169.

national health insurance program would also address the existing social problem of lack of access in conjunction with a mélange of sporadic charity care and means-tested inadequately funded government programs, with a proposed social solution of guaranteed access and payment.

c. Legitimate Role for Government

The major objection to a system of national health insurance is the increase in government intervention in health care. However, this is both a legitimate role for government and the responsibility of the government in ensuring the safety and security of the citizens. Furthermore, the government already plays a major role in ensuring the health of Americans.

American citizens, in common with all other humans and most if not all other life forms on planet earth, require air, water, and food in order to survive. In order to be healthy and thrive, people need clean air, pure water, and untainted food. These basic requirements are so vital that only the government is charged with the responsibility of ensuring all three. Clean air, pure water, and untainted food are too important to be left in the hands of the special interests. The government has both the authority and the responsibility to regulate, to monitor, and to take action in regard to what is critical to the health and well being of the citizenry. Assuming responsibility for financing a national health insurance system is the next logical step in protecting Americans and is as necessary as police, fire, and military protection.

National security is arguably the most vital responsibility of the federal government. Yet the conduct of war is not left in the hands of the generals, presumably those who would know best how to wage and win a war. National security always has

civilian oversight because war is considered to be too important to be left in the hands of the special interests. Why then should the health care system, arguably as important to domestic tranquility and general welfare as the military is to common defense, be left entirely in the hands and at the mercy of those who profit most from the existing system? Just as government has the authority, power, and responsibility to protect the people from external enemies and to regulate clean air, pure water, untainted food, safety and security, it should also have the authority, power, and responsibility to ensure, finance, and regulate access to health care.

A reformed health care system will necessarily include regulation and oversight and the manpower, budget, and authority to enforce regulations. A new universal access system must adhere to strict budgeting because anything less than tight control, especially during the start-up and initial implementation phases could have serious negative impact on the American economy. The runaway escalation of physicians' fees in the aftermath of Medicare must be avoided to make and keep the new system viable.

2. Magnitude of Task Must Not Defer the Beginning of the Movement

Neither the magnitude of the task nor the strength of the opposition should be permitted to defer the beginning of the work. William Lloyd Garrison began a movement that overturned an institution that had existed since at least the beginning of recorded history and most probably for millennia of prehistoric time, one that was economically successful and constitutionally protected. Elizabeth Cady Stanton began a movement that overturned the patriarchal social structure that had existed for millennia. A social reform movement comparable to the abolition of slavery or woman's rights and suffrage can overturn the current unjust and inequitable system of American health care, a system that

has been dominant for only about a century. The force of public opinion will be critical to the success of a Health Care Reform movement so it will be necessary to educate the American people and arouse their collective moral outrage at the inequities of the current system and the narrow self-interest of the opponents of reform. The American people are like a sleeping giant or the body at rest in Newton's first law of motion.⁶¹¹

According to the laws of motion, a body at rest will remain at rest but can become a body in motion by overcoming the force of inertia. One task of the Health Care Reform movement will be to overcome that force of inertia and mobilize the force of public opinion.

3. Recognize and Honor Political Dimension of Social Reform

It is also essential for a Health Care Reform movement, or any other social movement, to recognize and honor the political dimension of social reform. While moral outrage is necessary to begin the great work of social reform, it is not sufficient to complete that work. The work of social reform that begins with agitation in the streets at the grassroots level, and generates enough turbulence and public support to get the issue onto the national policy agenda, must move into the halls of government to be resolved. The redress of injustice must be accomplished through the political process. Moral rights must be transformed into legal rights and this can only be done through legislation.

⁶¹¹ Newton's first and second laws of motion, simply stated, are first, that a body at rest tends to stay at rest and a body in motion tends to stay in motion, and second, that to change a body at rest to a body in motion it is necessary to overcome the force of inertia.

C. Conclusion

The thesis of this dissertation is that a social reform movement will probably, perhaps almost certainly, be necessary in order to accomplish comprehensive reform of the American health care system because justice, as examined in Part One, demands reform and because nearly all attempts at effecting reform through the political and legislative processes, as examined in Part Two, have failed. Since the normal methods of accomplishing reform have not succeeded despite nearly a century of effort, it is time for the American people to look to a new paradigm as embodied in a social reform movement. Part Three of this dissertation has examined social reform movements, how they begin and develop in Chapter Five, and then taken a closer look at two past successful American social reform movements, Abolition in Chapter Six and Woman's Rights and Suffrage in Chapter Seven. The current chapter has focused on how a social movement for Health Care Reform might begin and develop, with special emphasis on pragmatic achievability.⁶¹²

The idea of a social movement for the reform of the American health care system thus has special significance for social activists, for all who would benefit from a reformed health care system, and for all who perceive that something needs to be done but are uncertain about what to do or how to do it. A reformed health care system and the process of achieving it also have implications for related fields such as health care ethics.

⁶¹² This means, essentially, finding a solution to the financing and distribution of health care that will be acceptable to most people. For example, a system of national health insurance, single payer government-financed, that guarantees universal access might be the best of all possible worlds. However, to insist on this type of system when it is highly unlikely to be acceptable to the majority is to invite one more failure to enact reform legislation. It might be better to take a more practical approach and create a system that is more acceptable to most people, perhaps even retaining, at least in part, the current market-based system but with significant restrictions, regulations, and government oversight.

D. Implications for Health Care Ethics

Since its inception, health care ethics has focused largely if not exclusively on the individual patient, ensuring that the individual is treated justly in interactions with the health care system. Particular attention has been and continues to be given to the relationship between the individual patient and the physician. Health care ethics has made substantial progress in securing basic rights, protection, and justice for the individual patient.

However, justice is a social virtue and attention must be paid to securing basic rights, protection, and justice for all, especially to those who are shut out of the American health care system as it is currently structured. Access to health care is one of the biggest challenges facing health care ethics at this time, of vital concern to the individual, the community, and society. Health care ethics, having achieved notable success in obtaining justice for the individual patient, could exert significant influence on the fight to obtain health care justice for all.

The field of health care ethics has experience in working with the health care system and because of this has standing in communicating with stakeholders. Thus, health care ethics should expand its field of vision to include access to health care for all as one of the major challenges to be resolved. The concern about fair treatment within the health care system is meaningless to those who cannot get access to the system.

This is not a change in focus so much as it is an expansion of the field of vision to look beyond the individual patient to the community and society as a whole. It is not a case of either/or, that is, either the individual patient or the community and society. Rather, it is a case of both/and, that is, both the rights of the individual patient and just

treatment, including access to the health care system, for all members of the community and society.

It is understandable that health care ethics has focused on the individual patient because these cases are much simpler, with fewer factors to consider and resolve. However, the communal and societal problems of access to health care for all must also be resolved in spite of the complexity of the issue and the number of factors involved. Health care ethics, with experience, expertise, and standing, may be in a unique position to answer the challenge.

E. Recap of Dissertation

This dissertation has focused on reform of the American health care system from the perspective of how to accomplish substantive, comprehensive reform by persuading Americans to become actively involved in the process and by suggesting a framework for an action plan for American activists to use in beginning the effort to accomplish reform. The dissertation has argued that a social reform movement might strengthen the political will to act to reform the American health care system. Recent success (March 2010) in enacting health insurance reform legislation notwithstanding, the need for American activism continues and grows.

The focus of the dissertation has been to inspire American activists to challenge Americans to accomplish comprehensive health care reform by beginning and sustaining a social reform movement to complete the work begun by the recent legislative success. The general thesis has been that a social reform movement for health care is in order and might be necessary because the system as currently structured is unfair and because most efforts to accomplish reform through the political and legislative processes have not

succeeded. The dissertation was developed in three parts, examining the issue of health care reform from three perspectives: Part One focused on Justice; Part Two focused on Policy; and Part Three focused on Reform.

1. Recap of Part One

Part One did not attempt to break new ground in developing a new theory of justice, but instead drew on extensive writings by scholars in the field and argued that Americans have a moral right to health care, a right that is not being honored under the American health care system as it is currently structured. Thus, since justice demands that a rights violation be redressed, Part One established a basis for calling for reform of the American health care system. Part One was developed in two chapters. Chapter One developed the thesis by drawing on various approaches to justice, examining several theories and definitions of justice, including social justice and distributive justice, and arguing that a moral right to health can be based on the Golden Rule (Ethic of Reciprocity) or the terms of fair cooperation justifiable in a democratic society that espouses freedom and equality for all. Chapter Two developed the thesis by moving from a theoretical understanding of justice that supports a moral right to health care to applying the theories to the practical problems of developing a just or more just health care system for Americans. Chapter Two examined the works of several scholars in the field,⁶¹³ analyzed their arguments, and argued that their work supports a moral right to health care on several bases but that it would take more than a moral right to accomplish reform in the practical sense. Further, although a moral right to health care may be

⁶¹³ The scholars are: Daniel Wikler; Norman Daniels; Madison Powers and Ruth Faden; and Erich H. Loewy and Roberta Springer Loewy.

necessary to call for reform, it may not be sufficient to persuade Americans to take action. Therefore the works of two other scholars⁶¹⁴ were examined, one of whom argues for a moral right to health care as a derivative of the obligation to aid those in need and the other of whom argues for a moral right to health care as a corollary of enlightened self-interest. However, this moral right would not be sufficient to accomplish reform because, in contemporary American society, a moral right must be transformed into a legal right in order to be recognized and honored and this can only be done through the political and legal processes. Part One thus led into Part Two for an examination of policy.

2. Recap of Part Two

Part Two of this dissertation focused on Policy, the high-level framework or plan of action that embraces the general goals and guides the decisions and actions of an organization or institution such as the government, with particular regard to health care policy. Policy is an important step on the road to health care reform because it will ultimately provide the foundation that will transform the moral right to health care, as supported by Part One of this dissertation, into a recognized legal right. Part Two was developed in two chapters. Chapter Three developed the thesis by presenting a general introduction to policy and an overview of different categories of health care systems and examining the health care systems of four representative nations: Germany, Great Britain, Canada, and France. Chapter Three argued that the health care systems of the paradigm nations, in common with nearly all other nations that have developed universal

⁶¹⁴ The scholars are Charles J. Dougherty and Larry R. Churchill.

access health care systems, developed on the basis of the health care system that already existed. This could be of significant relevance and also a valuable lesson for American reformers, that reform is more likely to succeed through evolutionary, not revolutionary, change. Chapter Four developed the thesis by examining America's social welfare policy, specifically five paradigms,⁶¹⁵ to determine whether and how the repeated failures of health care reform might be overcome. The focus was pragmatic achievability, presenting practical suggestions to create a workable solution to what has heretofore been an insoluble problem. Chapter Four argued that the American people were actively involved in the two successful attempts to enact social welfare legislation, Social Security and Medicare, but that such activism was missing in the other attempts,⁶¹⁶ and that therefore the active involvement of the American people may be necessary in order to accomplish reform. Part Two thus led into Part Three and an examination of how reform may be accomplished.

3. Recap of Part Three

This dissertation has proposed an alternative method for achieving reform through the active involvement of American citizens fomenting a social reform movement to accomplish the reform that has not been achieved through the political and legislative processes. A social reform movement would not replace political effort but would instead both complement and supplement the work of the political and legislative processes. Thus, Part Three has focused on Reform, specifically on how social reform

⁶¹⁵ The five paradigms are: FDR and Social Security; Truman and national health insurance; LBJ and Medicare/Medicaid; Nixon and HMOs; and Clinton and the Health Security Act.

⁶¹⁶ The three unsuccessful attempts to achieve reform of the American health care system were: National Health Insurance under Truman; HMOs under Nixon; and the Health Security Act under Clinton.

movements accomplish reform and how a social movement for health care reform might begin and develop in contemporary American Society. Part Three was developed in four chapters. Chapter Five developed the thesis by providing necessary background information on social reform movements in general, what they are and how they accomplish reform. Although social reform movements usually begin when governments are unable or unwilling to take necessary action to redress injustice, the ultimate resolution of the injustice must be accomplished through government action. Chapter Five argued that government must play a role in both accomplishing reform and the newly reformed social program. Chapter Six developed the thesis by examining the work of the first American social reform movement, abolition, and extracting lessons that may be applied to a contemporary social movement for health care reform. Chapter Seven developed the thesis by examining the work of the second American social reform movement, woman's rights and suffrage, and extracting lessons that may be applied to a contemporary social movement for health care reform. These two social movements were examined because they developed somewhat differently and thus have unique as well as common lessons for contemporary social reform activists. Chapter Eight developed the thesis by clarifying the work to be done by American social reform activists in beginning and sustaining a health care reform movement and by addressing implications for related fields such as health care ethics.

F. Concluding Thoughts

What has been said in this dissertation is neither complete nor comprehensive in regard to what fomenting a social reform movement entails, and it is not intended to be a cookbook, with all ingredients listed and precise instructions on preparation. Rather, this

dissertation, and specifically this chapter, provides suggestions, primarily practical, on how to get started. The movement will be and must be a living entity that will take on a life of its own and suggest new methods and techniques of spreading the message, to new and ever-increasing audiences, using new symbols, and with renewed hope of success.

Although it is far from certain whether an American Health Care Reform social movement can actually achieve a reformed system of national health insurance, it is nearly certain that comprehensive health care reform will not be accomplished without such a social reform movement. No rational person would have wagered on the success of abolitionism or woman's rights and suffrage, yet both were accomplished. In each case a visionary came forth to organize, channel, and give voice to the imperfectly formed and unvoiced discontent of at least some of the American people with the institution of slavery and the patriarchal subjugation of women. Health Care Reform awaits the visionary, for discontent with the current health care system already exists.

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